UNITED STATES DEPARTMENT OF EDUCATION

OFFICE OF POSTSECONDARY EDUCATION

NATIONAL COMMITTEE ON FOREIGN MEDICAL EDUCATION AND ACCREDITATION

OPEN SESSION

Monday, March 30, 2009

8:00 a.m.

The Madison – Loews Hotel
John Adams Room A & B
1177 15th Street, N.W.
Washington, D.C. 20005

P A R T I C I P A N T S

COMMITTEE MEMBERS PRESENT:

J. LEE DOCKERY, M.D., Chairperson

RAYMOND F. CARON, M.D., Committee Member
MARTIN CRANE, M.D., Committee Member
JAMES A. HALLOCK, M.D., Committee Member
JOHN J. JUCAS, M.D., Committee Member
PAUL F. La PORTE, Student Committee Member
NORMAN I. MALDONADO, M.D., Committee Member
DAVID R. MUNOZ, M.D., Committee Member
KIRAN H. SHAH, M.D., Committee Member
DENNIS K. WENTZ, M.D., Committee Member

U.S. DEPARTMENT OF EDUCATION STAFF PRESENT:

MS. ROBIN GREATHOUSE, ASL Staff
MS. BARBARA HEMELT, FSA Foreign Schools Team
DR. JENNIFER HONG-SILWANY, ASL Staff
MR. WILLIAM JAMES, ASL Staff
MS. JOYCE JONES, ASL Staff
MS. MELISSA LEWIS, NCFMEA Executive Director
MR. STEPHEN PORCELLI, ASL Staff
DR. NANCY REGAN, ASL Director
MS. CATHY SHEFFIELD, ASL Staff
DR. RACHAEL SHULTZ, ASL Staff
MR. JAMES SNEED, ASL Staff
MS. SALLY WANNER, OGC Attorney

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P R O C E E D I N G S

8:02 a.m.

DR. DOCKERY: Good morning, everyone. If we could please take our seats, and we will begin this morning's session. I'm Lee Dockery and Chairman of the Committee, and I'm professor in the University of Florida College of Medicine, also Trustee of the McKnight Brain Research Foundation.

It's a pleasure to have you here today, and for all of those people who traveled for a long distance to participate in our discussions, we appreciate very much your time and effort.

So that we can get to know each other today, let's go around the room and introduce ourselves, and I would ask all those people who are guests and seated in the back, also stand and state your name and the country that you represent or your title if you should be staff, so let's start with you Dr. Hallock?

DR. HALLOCK: Good morning, I'm James Hallock. I'm President of ECFMG,

Chairman of the Board of -- Good morning, Jim Hallock, President of the ECFMG, Chairman of the Board of FMEA, and a member of the Committee.

MR. La PORTE: Hi there. I'm Paul La Porte. I'm an M.D., Ph.D. student at the University of Chicago.

DR. CRANE: Dr. Martin Crane, I'm the Chair-Elect of the Federation of State Medical Boards and former Chair of the Board of Medicine of Massachusetts and a member of the Committee.

DR. JUCAS: My name is John Jucas. I'm a dermatologist in private practice in El Dorado, Arkansas, and a member of the Committee.

DR. MUNOZ: I'm Dr. David Munoz, in practice in geriatrics internal medicine and a member of the Committee.

DR. CARON: Raymond Caron, general pediatrician from Orlando, Florida; faculty member of the University of Florida as well as Nova Southeastern.

DR. SHAH: Kiran Shah. I'm a practicing physician and also a surveyor for the Joint Commission.

DR. MALDONADO: Norman Maldonado. I'm Professor of Medicine, University of Puerto Rico.

DR. WENTZ: Dennis Wentz from Colorado, formerly at the Group on Medical Education, American Medical Association, and a member of the Committee.

MS. LEWIS: Good morning. Melissa Lewis, Executive Director of the NCFMEA, U.S. Department of Education.

DR. DOCKERY: If we could start in the back please, and we'll start with this front row please.

(Off-Mic Audience Introductions.)

DR. DOCKERY: Does that include everyone? Well thank you again for coming, and helping us to do our work and participate in the deliberations.

Just a few words about the purpose for the Committee. The Committee's purpose is

to evaluate the countries' accreditation standards to determine their comparability of the U.S. accreditation standards.

This is an optional process which the country voluntarily submits an application to determine comparability, so our role is to review those accreditation standards and to determine their comparability as it relates to comparability of the standard used by the United States medical schools in the accreditation of their schools.

The purpose of this of course is very important, and if those countries are determined to have comparable accreditation standards, then American students who are enrolled in those universities are eligible for the Federal Student Loan Program in the United States.

If they are determined to have comparable standards, then they must apply for institutional certification to be eligible for access to the Federal Student Loan Program.

I'd like to stress again that we do

not accredit medical schools. We only determine the comparability of countries utilizing the accreditation standards for the accreditation of their respective medical schools.

At this time I would like to call on Melissa Lewis who will describe our procedures and process that we'll utilize throughout the day, but before doing that, I'd like to let you know that Dr. Maupin has resigned from the Committee, and Dr. Martin Crane who has introduced himself before will not be here for tomorrow's deliberations. Ms. Lewis.

MS. LEWIS: Thank you. Thank you, members. I appreciate your volunteering your time to serve on this Committee and all the hard work that goes into the preparation for the meeting.

It's an honor to serve our Chair and the esteemed Committee members. I also want to extend a warm welcome to our international guests. Thank you for coming so

far. It is appreciated, and before we begin in earnest, I would also like to thank all the accreditation and state liaison staff members who work diligently to prepare for the meeting.

I'd especially like to thank Dr. Nancy Reagan, the Accreditation and State Liaison Director, along with Kathy Sheffield and Robin Greathouse. If you'd please stand. They will not be coming to the presenters' table today, but they all put in long hours to make this meeting possible. If you could join me in thanking them with your applause.

Other department staff that I'd like to acknowledge for their invaluable assistance include Ms. Sally Wanner from the Office of General Counsel who will be joining us shortly just to my left along with Ms. Barbara Hemelt and Ms. Geneva Leon from the Federal Student Aid Office of Program Compliance in Foreign Schools Team. We appreciate all the support from our staff members that goes into making a successful

meeting.

For those of you who have not picked up handouts, we have a materials table back in the corner of the room with all the materials including the agenda which has a blue sheet as well as many other handouts back there.

I also wanted to let you know that recording this session today is John Mongoven, directly behind me, our court reporter, who will be responsible for transcribing all of the proceeding. So with that in mind, I'd like to remind the members to please when you speak, come up to the microphone and be sure and turn it on, but when you're finished, also be sure you turn it off because it affects the volume for the next speaker.

Then the rest rooms -- the ladies' rest rooms are directly across from the meeting room, but the men's rooms are down the hall almost to the end. If you take the last left and then a quick right, you'll find the men's room, and then also the Committee will

go into Executive Session when reviewing countries, and we'll ask our guests to depart for a few moments.

We have chairs set up just as you exit this room, they're to your right and a quick left. It's like -- you'll see a number of chairs and a kitchen-like buffet area.

One last message, as always, if you have a cell phone, we request that you turn if off or to the vibrate mode, and with that, I'd like to turn it over back to Dr. Dockery.

DR. DOCKERY: I think the Committee members will join me in recognizing that Ms. Lewis has praised everyone else except herself, and we've been dutifully involved with preparing our report and review, so please join me in applauding Ms. Lewis also.

At this time we'll go ahead then and start our business, and we will ask for the review of Cayman Islands, and I believe Dr. Jones. Just remind you in terms of the process, when we hear a country's application, we will review first of all the staff analyst, and then we

will invite any guests who are in the audience to appear at the discussion table for any preliminary questions by members of the Committee, after which we will go into Executive Session to discuss the application and the concerns of the Committee.

The reason that we go into Executive Session is because these deliberations are confidential until the Secretary notifies the country of those deliberations, so even when we have the representatives of a country that is under discussion for consideration, we ask that those decisions that are made in Executive Session likewise not be communicated until the official letter from the Secretary is received.

Are there any questions about the procedures before we begin? Dr. Jones, good morning.

MS. JONES: Good morning, Dr. Dockery and to the Committee Members. I'm pleased to present you with a summary of the

petition for redetermination of comparability submitted by the Cayman Islands.

In September 2002, this Committee initially determined that the accrediting system used by the Cayman Islands to evaluate medical schools was comparable to the system used in the United States.

Before you made your comparability determination, the Government of the Cayman Islands officially designated the Accreditation Commission on Colleges of Medicine, which I will refer to as the ACCM or the Commission.

It was designated as the agent to evaluate the medical education program offered at the St. Matthew's University School of Medicine, which I will refer to as SMU or the College.

SMU is the country's only medical school. The ACCM members representing the Cayman Islands are present pursuant to the country's designation. There are no schools in the Cayman Islands that participate in the

Federal Family Education Loan Program. According the ACCM, SMU has applied to participate in the FFEO Program and awaits the Department's approval.

Since 2002 the ACCM has presented summaries of its past, present, and future accrediting activities in the Caymans as are related to SMU.

At your March 2008 meeting the ACCM reported on the accrediting activities it conducted through November 2007. This Committee accepted the report and invited the country to reapply for a comparability redetermination for review at this meeting.

Therefore, this presentation summarizes the current application. The standards and processes used by ACCM apply to its evaluation of medical education programs and remain substantially comparable to the guidelines established by this Committee.

However, the Department's staff analysis disclosed three areas of concern that the Committee may want to discuss with the

ACCM, and they are: (1) Whether inconsistent laboratory experiences within the basic science curricula at different sites affects the quality of the educational program and impacts student learning; (2) whether the ACCM policy limiting medical student access to their medical school records is consistent with the NCFMEA guidelines; and (3) the ACCM does not have written policies or protocol regarding the impact of its assessment of School B when the inspection team visits a clerkship site during its evaluation of School A, and the team also interviews students from School B who have a valid affiliation agreement to perform clerkships at the same clinic site.

First a variance exists between the ACCM laboratory course requirement and the basic science curriculum which was reported in the SMU self-study and the information provided in the application narrative.

The ACCM does not have an accreditation standard regarding laboratory

requirements for specific courses in the basic science curriculum.

In addition, the ACCM has not demonstrated how not having a standard impacts the basic science curriculum. Department staff is uncertain if, in the absence of a defined practice, the ACCM can show a pattern of consistency that will not impact student achievement.

The ACCM protocol allows an inspection team to report on the content instruction of the curriculum, whether the school meets its educational goals, and the role of the curriculum committee in overseeing the curriculum.

The ACCM admits that it does not have an element or standard of accreditation that specifies the laboratory courses required in the basic science program.

To remedy this concern, the Agency indicates that it will look at the clinical science disciplines to ensure support in -- I'm sorry, for clinical pathologies in its

elements or standards of accreditation.

The Department staff remains concerned about the laboratory requirements for specific courses in the basic curriculum under Section 4.2 of your guidelines and not under 4.4 as referred to in the Agency response, and that specifically is the difference between the requirements for the basic science curriculum and that for the clinical curriculum.

In addition, ACCM requirements regarding the laboratory curriculum in the basic science courses are not reflected in the SMU self-study. The SMU self-study offers several different courses other than those published in the ACCM basic science requirements.

Department staff anticipates that the ACCM will discuss this concern today and offer a plan to revise the elements at its own meeting in May 2009.

Next, Section 5.1 of the guidelines requires medical schools to make student

records available for review and give the student an opportunity to challenge their accuracy. The ACCM Element 5 addresses a student's access to review the current -- the accuracy of his or her records.

However, the ACCM appears to limit student access only to seeking redress from an adverse action.

The intent of the guidelines is to ensure that students have access to the records at any time and not only when adverse issues arise.

In response to the staff analysis, the ACCM acquiesces that the elements of accreditation limit a student's access to the school records. ACCM reports that during its May meeting it will revise the elements of accreditation to ensure that students may access their school records at any time.

Finally, Part 3 of the guidelines allows an accrediting agency that accredits multiple schools that use a common core clinical clerkship site have -- and has a

single coordinator responsible for the educational experience of the students from each school, and the team interviews the students from all schools at the common site at least once during the accreditation period.

The ACCM conducts accrediting activities for the countries of Saba and St. Maarten in addition to the Cayman Islands. The accredited medical schools located in these countries often use the same facilities for their clinical clerkships.

The ACCM does not have a protocol to address the impact of a site visit to a clinical clerkship serving students from several schools that it accredits.

Also the ACCM elements or protocol fail to indicate that the ACCM will conduct an on-site review within 12 months of the placement of students at sites never visited by the Agency. It would be helpful if ACCM developed a protocol addressing this process or the process it uses to review a clinical site that hosts students from more than one of

the medical schools it accredits.

In its response, the ACCM notes that it does not have a written protocol or element to inform countries with common clinical facilities of its practices. Therefore, it will ratify these elements and the protocol when its commission meets in May 2009.

The ACCM written response clearly indicates its desire to make the changes suggested when it meets in May, and this concludes my presentation, and I am prepared to respond to any questions you may have about the staff analysis. Thank you.

DR. DOCKERY: Thank you, Dr. Jones. Are there any questions from members of the Committee before we ask the representatives from the ACCM to join us at the table? Dr. Temperley and Dr. Peacock, good morning. Is Dr. Bresnihan -- is he going to be joining you also?

Dr. Jones vacated, so he's permitted.

DR. TEMPERLEY: Thank you. First of all it's very nice to meet you and meet Ms. Lewis, and I thought I would probably try and speak to this discussion group if I can because I have just a small difficulty in sort of getting extemporary words out clearly.

The report to the NCFMEA on the Cayman Islands Government, there is only one medical school in the jurisdiction of Government of Cayman Islands, Saint Matthew's University School of Medicine. The Educational Council grants approval for the school to be registered in Cayman Islands in April 2002.

Prior to this, the school was located in Belize. There have been no changes in the laws of the Cayman Islands Government affecting the accreditation of Saint Matthew's since 2003 report -- 2007 report.

The Government continues to recognize ACCM as the official body to evaluate and accredit Saint Matthew's. There have been no changes in the accreditation

standards, processes, and procedures used to evaluate Saint Matthew's. The ACCM has accredited the medical school for a six-year period to June 2013.

For four years leading up to 2007/2008, the enrollment matriculating applicants have reached 425 per annum. The mean pre-medical GPA in 2007/2008 was 3.1.

Due to prevailing financial circumstances in the U.S., matriculating students are expected to fall to 320 in 2008/2009. One of the most significant changes has been that students entering fifth semester subsequent to August 2007 are required to pass USMLE Step 1 prior to entering clinical science semesters.

At its meeting in March 2008, the NCFMEA heard testimony from Drs. Tony Peacock and Clive Lee of the ACCM. Among the issues raised was the high standard of a first-time pass rate from students in the USMLE Step 1 examination. That is 90 percent.

The ACCM examined this issue

carefully. In 2007/2008 the number of students permitted to take Step 1 for the first time was determined by their ability to pass the final basic science examination. Of this select group of students, the first-time pass rate in Step 1 was 92 percent, however, based on the number of students in the fifth semester, the first-time pass rate was 85 percent.

In September 2008, the Honorable Alden McLaughlin, Minister of Education in the Cayman Islands, was informed that the NCFMEA was scheduled to review information regarding the standard use by the Cayman Islands for accrediting medical students for the redetermination of comparability.

The NCFMEA was organized to meet on the 30th or 31st of March 2009. As the ACCM is responsible for accrediting the only medical school in the Cayman Islands, it was asked to accept responsibility for the report by the minister.

To the best of its ability, the

ACCM answered all the questions posed in the NCFMEA Guidelines for requesting a comparability determination revised September 2007.

The ACCM report was duly made available to the Cayman Islands Government and the U.S. Department of Education by December 15, 2008. The Department staff analysis of standards for evaluation of medical schools used by the Cayman Islands arrived just as promptly, being prepared in January 2009.

The ACCM appreciates the work undertaken by the U.S. Department of Education on behalf of the Cayman Islands Government and the ACCM. The U.S. Department of Education staff analysis indicates that the standards and the processes that the ACCM applies to its evaluation of the medical education programs remain substantially comparable to the guidelines established by the NCFMEA.

Among many other issues accepted by the Department of Education, it disclosed three areas of concern. Dated February the

20th, 2009, ACCM replied in writing, as a result of the issues raised by the Department of Education in its staff analysis, the ACCM at its meeting in May 2009 will be requested to incorporate the aforementioned issues into the elements of accreditation and where necessary into the protocol.

This document is prepared on behalf of the Government of the Cayman Islands and the ACCM. Dr. Peacock and I will be happy to answer any questions which may arise. Ian Temperley.

DR. DOCKERY: Thank you, Dr. Temperley. Dr. Peacock, do you have any additional comments?

DR. PEACOCK: No, Chairman, not at this time. As I said, we'd be very willing to take any questions that may arise from the both written submission and also the verbal submission this morning.

DR. DOCKERY: Are there questions from members of the Committee before we go into Executive Session?

If we could ask our guests please to depart, and we'll go into Executive Session.

EXECUTIVE SESSION

END OF EXECUTIVE SESSION

DR. DOCKERY: Thank you again for coming and being with us, and wish you bon voyage, Dr. Temperley. We'll miss you. I'm sure you'll miss us. Say yes, say yes.

Thank you again. At this time I'd like to recognize and thank Ms. Sally Wanner who has joined us again for our deliberations. She is legal counsel and has been just been invaluable support to the Committee, and also I see Barbara Hemelt is in the audience from Federal Student Aid, and we appreciate all of her help in being with us, and Mr. Dan Madzelan is with us also, and I understand we're going to hear from you today.

Mr. Madzelan, would you like to address the Committee at this time?

MR. MADZELAN: Good morning. I am Dan Madzelan, and I am currently delegated the

authority to perform the functions and duties of the Assistant Secretary for Postsecondary Education, but if you want to say Acting Assistant Secretary, that's fine with me.

DR. DOCKERY: Does it have an acronym?

MR. MADZELAN: I'm sure it does. I haven't bothered to memorize it yet. Thank you, Lee, and thank you for your leadership of the National Committee on Foreign Medical Education Accreditation. It's a tribute to your management interpersonal skills that the Committee has come so far since you became Chairman in spring 2007.

I want to acknowledge our foreign guests for being here and for their commitment to working with us to increase the quality of medical education programs globally.

We recognize the time and money that you and your country invested to take part in this meeting.

I would like to thank the NCFMEA members for their service to this body and for

the dedication accomplishing the Committee's important work.

Both the Department and the NCFMEA have a fiduciary duty and a statutory responsibility to serve consumer and taxpayer interests in this field of higher education just as we do in other fields.

Thousands of students who receive millions in Federal student loans to attend foreign medical schools count on this body to ensure certain quality standards for medical education programs are maintained.

Your service to your country is particularly important at this critical time, as the administration reviews this country's health care policies and as the Committee prepares a report for the Secretary and Congress with recommendations regarding institutional eligibility for some foreign medical schools to participate in the Federal student loan programs.

At this time I especially want to recognize one of the NCFMEA members for his

contributions. Dr. Norman Maldonado, could you please join me.

I understand that Dr. Maldonado's experience concerning medical education programs in the Caribbean and Latin America is often recognized by others as well as this Committee, and that Committee has previously considered his translation skills invaluable in translating representatives' statements before the group.

In honor of his ten years of Government service on the NCFMEA, it is my privilege to present Dr. Norman Maldonado with this certificate and pin, and the certificate is from the Department of Education recognizing ten years of service. As well as the handsome pin with the eagle with the numeral ten again reflecting ten years of service.

DR. MALDONADO: Thank you very much.

MR. MADZELAN: Thank you.

The Committee please stand and

recognize Dr. Maldonado.

DR. DOCKERY: If I also could interrupt and say it's not only his translation skills that he's contributed to this Committee. It's been invaluable in other areas also.

DR. CARON: I second that motion, Lee.

MR. MADZELAN: I have one of those somewhere back in the office too. It's a few years of service of here. I'm very glad to have the opportunity to talk to the Committee today, and I'm grateful that you're such a resolute group with an extreme wealth of experience in the field of medical education.

You've all worked on issues involving medical education and/or licensure in this country as well as on international medical education, and together you have accumulated close to four centuries of experience in medical profession. Yes, a wealth of experience indeed.

If you ever doubt the need or

appetite for the Committee's mission, consider the following. As of January 6 this year, more than $315 million in Federal loan monies was certified by 28 free-standing foreign medical schools in 12 countries for almost 7400 borrowers last year.

Three foreign medical schools, Ross University located in Dominica, St. George's University School of Medicine in Grenada, and American University of the Caribbean in St. Maarten certified $293 million or 93 percent of the amount going to free-standing foreign medical school students or 44 percent of the total Federal family education loan program amount disbursed to all foreign schools.

Also notable, the foreign school cohort default rate was a low 1.2 percent for the most recently calculated year. That's the 2006 cohort default rate that we announced last September. I think the national total was approximately five percent, so 1.2 percent indeed, a very strong showing.

The comparability determination

review that NCFMEA performs helps maintain public trust and how those Federal student loan dollars are spent.

Speaking of Federal student aid, you may have heard last month, just about a month ago, the President announced his fiscal 2010 budget blueprint, and for the student financial aid programs a couple of very significant proposals, one for the Pell Grant Program to make that a full entitlement, our largest need-based grant program for undergraduate students, and also to move the student loan program, recognizing the problems and disruptions over the past year in the credit markets, to ensure continued availability of student loans for all of our borrowers including yours or including those at foreign medical schools, to move that program over to direct loans, so it would be a single source of financing for Federal student loans.

Now, of course, that will provide some challenges for the Department, but we

feel that we are up to the challenge and were the President's plan to be accepted by the Congress beginning July 1st, 2010, all Federal student loans would be originated through the Education Department.

The NCFMEA's role is also an essential one in helping assure that the standards used in medical education programs are comparable to those used in the U.S. medical students often in the U.S.

Medical students often want to know how well an institution serves their aspirations and at what cost. This is a reasonable expectation especially given their medical education of one of the most important, costly, and time-consuming investments they'll ever make.

Through the NCFMEA's comparability determination process, U.S. student borrowers attending foreign medical schools are able to base their actions on a more full and complete understanding of their options.

Policymakers are better able to

assure taxpayers that the foreign institutions receiving their support are reputable and effective.

Graduate medical education programs and employers are better able to see that graduates are prepared to do their jobs, and foreign countries and their creditors are better able to refine and improve their offerings.

I realize that achieving these goals is an extremely difficult task. That's all the more reason to be ever mindful of our responsibilities to students and their families.

In closing, thank you again for coming here today. Your interest and commitment to maintaining high accreditation standards for international medical education are appreciated. Your work will ultimately influence the quality of medical care provided by health professionals throughout the world.

I'd be happy to take a few questions from the Committee at this time.

Thank you.

DR. DOCKERY: Thank you, Mr. Madzelan. Are there questions from the Committee? While they're thinking of them, may I ask one?

MR. MADZELAN: Sure.

DR. DOCKERY: You said the Committee work is very important, and we're facing several expirations of terms. We have Dr. Maupin who has resigned, and Mr. Maldonado is going to do other great things, so we already have two vacancies. Is the Department considering these vacancies and will they be made -- appointments be made in a timely fashion, because you know we had a hiatus of a couple of years when we had some appointments that were delayed, so what is your thought in terms about keeping the Committee functioning and without losing momentum?

MR. MADZELAN: Yes, indeed the Committee will remain functioning, and the Department certainly will make nominations. I just hesitate a little bit on the timely part

only because obviously we have a new administration, and a number of our advisory committees are in similar circumstances with terms having expired, persons needing to be nominated not only by our Department but also in some cases by the Congress, and as you know, at the -- you know, at the subcabinet level certainly across -- certainly the domestic agencies, you know, the administration is filling, the Assistant Secretaries, Deputy Undersecretaries, etcetera, and as well as various boards of advisors.

Now there is obviously the vetting clearance nomination process, and there are, I can assure you, I've met them, people now with the Department that are working more than full time on getting people in place and getting people in place meaning all of those who need to be nominated, in some cases confirmed, but as well as clearance by and approval by all the appropriate offices not only within the administration -- within their department but

also within the administration.

So it will happen. It is coming. I can certainly take this message back to the people that I talk to on a daily basis and relay to them and express your urgency and desire to -- for continuity within your Committee to maintain your momentum.

DR. DOCKERY: Thank you very much. Are there other questions from members of the Committee? Dr. Hallock.

DR. HALLOCK: Doesn't the same thing hold for the re-nomination process? Aren't there several folks coming up for re-nomination in September?

DR. DOCKERY: Yes, that was imbedded in the question so that we have several terms that are expiring in September, so we have either facing a full turnover or for those people who decided not to continue to serve so we want to be sure that we're identifying people who are willing to serve and then we have that appointment process that can be expedited, and I feel comfortable that

you expressed. I noticed that you paused on timely, but hopefully you'll keep your eyes on us.

MR. MADZELAN: Yes, indeed, and that is -- as I say, I will. I'm serving in my current position until someone is announced, nominated, confirmed, and sworn in, and we know that sometimes takes awhile.

The other thing that I point out to people is although I'm not interested in this position, my taxes are up to date and paid in full.

DR. DOCKERY: Did you use Turbo Tax?

MR. MADZELAN: As a matter of fact, I do, but I am an uncomplicated financial man.

DR. DOCKERY: Are there other questions from the Committee? Well again, thank you so much for coming and being with us, and keep your eyes on us now.

MR. MADZELAN: I will.

DR. DOCKERY: Okay. Next we will go to the country of Saba, and we'll ask Mr. Sneed to

come forward.

MR. SNEED: Well good morning, Dr. Dockery, Committee, Committee Members, and guests. I am presenting the staff analysis for a report submitted by the ACCM, Accrediting Commission on Colleges of Medicine on behalf of the Government of Saba.

Saba University School of Medicine is the country's only medical school. You will find the materials related to this report under Tab K.

The NCFMEA initially determined that the standards used by the commission to evaluate Saba University School of Medicine were comparable to those used to evaluate medical schools in the United States at its March 2003 meeting.

At that meeting, the ACCM was directed to submit a full report for review at this Committee's September 2004 meeting. Based on the testimony and information, the Committee accepted the report and requested a follow-up report of its accrediting activities

for review at the September 2006 meeting.

There were no NCFMEA meetings for the years 2005 and 2006. The previously requested report was submitted, reviewed, and accepted at the June 2007 NCFMEA Committee meeting.

During that meeting, the Agency mentioned that Saba University School of Medicine would be going through a change of ownership. As a result of that change of ownership notification, this Committee requested that ACCM provide a report concerning the change of ownership of the Saba University School of Medicine for consideration at this meeting, and in response to that change of ownership report request, the ACCM conducted an on-site visit evaluation of Saba University School of Medicine in the fall of 2008.

After receiving the staff's self-study, the ACCM proceeded in accordance with its policies, and within six months notification of the change of ownership and

provided a report to its council.

The purpose of the site visit was to establish whether the new owners could ensure continuing compliance with the present accrediting standards. During the onsite inspection, the team met with a representative of the new owners of the school. It was reported that the new owners were generally happy with the organizational framework of the school but planned to arrange for a substantial investment in consulting experts to advise them on various matters such as updating the school's informational technology system and other matters.

The inspection team reported that the school was undergoing a multi-phase building program. The facilities under construction created new facilities for faculty, the new labs, new student lounges, new state-of-the-art classrooms with the latest technology for teaching aids, a new testing center, a new cafeteria for student union. All but the new testing center were

completed by September 2008.

There were no significant findings reported by the inspection team in their accrediting report of Saba University School of Medicine.

Based on a review of the report submitted by the Accreditation Commission on Colleges of Medicine on behalf of the Government of Saba, the Department staff concludes that the ACCM provided all of the information previously requested by this Committee.

The Agency is due for a full redetermination by this Committee at the September 2009 NCFMEA meeting.

There have not been any known Title IV funds disbursed to this country to date. There are representatives here today to receive your questions. I will be happy to answer any questions that you may have at this time. Thank you. This concludes my report.

DR. DOCKERY: Thank you, Mr. Sneed. Are there questions from members of the

Committee before we ask representatives from Saba to approach the table. Dr. Peacock. Dr. Peacock, good morning.

DR. PEACOCK: Good morning.

DR. DOCKERY: Professor Fitzgerald, good morning. Any comments that you'd like to make before -

DR. PEACOCK: Absolutely, sure. Well first of all I would like on behalf of the ACCM to thank Mr. Sneed once again for his extremely comprehensive analysis of the information submitted. As you know, this is a very narrow term of reference that the ACCM was instructed to provide back at the September 2007 meeting, and that was to -- the ACCM was directed then purely to present a report on the change of ownership.

Now one may argue that, you know, within -- as a result of protocol of course that the ACCM must follow, an inspection team must visit the basic science campus within six months of a change of ownership taking place, and one may argue well, six months, does that

give people sufficient time and so forth, and to the answer to that I suppose, well, you know, that's neither here nor there.

The point about it really is that that's what's written in the protocol, and that's what the ACCM team abided by, but the within that -- after that six-month change of ownership, we certainly were very favorably impressed by the new regime.

I think this was predominantly due to the fact that the new owners took over a school that was in pretty good shape already. I mean the ACCM has been accrediting this school since 2002, and I think that there would be some very favorable aspects to this particular school, and Number One, I think it's predominantly because of its relatively small size, and there's a very good, healthy student-faculty ratio and so forth.

So we also added in an institutional self-study which was completed towards the end of 2008 which I think would reflect further on the change of status within

the school now as a result of the change of ownership.

But our general impression based on the 2007 and indeed I might add just for the record that as part of the redetermination of comparability, an inspection team went out to the university in February of this year so that gave us a very good impression as to how things had proceeded over that period of time, so we nearly had a sort of a two-year window to see as to how the school was performing.

Our general impression really was, Number One, that personnel has been increased. That includes an increase in basic science faculty, clinical faculty, and also in administration staff. Small class size is still being maintained. There has just been small, modest increase in class size by about five to ten per semester take, and that brings the average take to about 75 students per semester.

There have been markedly expanded physical facilities to incorporate all the

various aspects that Mr. Sneed has mentioned. There is an enhancement of information technology. They are going to bring in the new ANGEL online platform educational platform which will tend to standardize the curriculum and make reporting of results and so forth much easier and is an extremely good education tool.

We have seen it in operation in other schools we accredit, and this has certainly made a very positive difference on the student experience.

There is also being I suppose -- this university has maintained relatively affordable tuition compared to other schools. There's been a very high morale of faculty is still being maintained with a relatively low turnover.

There is also great access to faculty by students, which students very openly report. They'll certainly report anything as we all know if anything -- if things are going wrong, but they were

certainly not behind the door in reporting the fact that they are very happy with their access to their teachers.

Also we would feel that admission standards have been maintained, and the USMLE Step 1 pass rate is also still within the guidelines and recommendations of ACCM.

The attrition rate of the school is comparable to the United States schools, and there is an ACGME residency site -- all students should I say can only go to ACGME residency approved sites for their clinical training.

So, therefore, the -- based on that particular visit the ACCM essentially felt that there was no negative impact on the school, an actual fact that the whole situation had become that bit more positive by the fact of the increased investment in what I've already said. Thank you.

DR. DOCKERY: Are there questions from members of the Committee before we go into Executive Session?

Professor Fitzgerald, any comments before we go into Executive Session?

PROF. FITZGERALD: No, sir, I think Dr. Peacock has put it very well, very succinctly.

DR. DOCKERY: Then we'll ask our guests to depart, and we'll go into Executive Session please.

EXECUTIVE SESSION

END OF EXECUTIVE SESSION

DR. DOCKERY: While the guests are returning, I would like for us to consider finishing Taiwan, and then we'll take a short break and then reconvene and if we could be -- manage our time well so that we can stay on schedule.

DR. DOCKERY: Dr. Hong-Silwany, good morning.

DR. HONG-SILWANY: Good morning.

DR. DOCKERY: I think we can begin. Thank you.

DR. HONG-SILWANY: Thank you, good morning, Mr. Chair and Committee Members. I will now summarize the analysis for the Taiwan

Medical Accreditation Council submitted on behalf of the Government of Taiwan. The materials are behind Tab M. I will refer to the accrediting council as the Council.

In March 2002 your Committee first determined that the standards and processes used by Taiwan were comparable to standards of accreditation applied to M.D. programs in the United States.

At the September 2004 meeting you requested that Taiwan submit a report on its accreditation activities involving its medical schools. This report was reviewed and accepted at the September 2007 meeting.

The Council is now before this Committee for redetermination of comparability. Based on information provided by Taiwan, Department staff concludes that Taiwan’s standards and processes for evaluating medical schools are comparable to those used in the United States.

Taiwan has submitted thorough documentation that portrays a reflective and

deliberate approach to the processes and standards they use to evaluate medical schools.

They openly acknowledge their challenges in implementing reform, as well as their plans for addressing these challenges. The future goals reflect to continuous improvement of their processes and standards and an aim toward increased comparability with the processes and standards used by the U.S. to evaluate medical schools that offer programs leading to the M.D.

Taiwan currently does not have any medical schools participating in Title IV programs.

Representatives from Taiwan are here today, and this concludes my presentation. I'm available to answer any questions you might have.

DR. DOCKERY: Thank you, Dr. Hong-Silwany. Are there questions from members of the Committee? We'd ask the representatives from Taiwan to please approach the table.

Good morning. Nice to see you again.

DR. LAI: On behalf of Taiwan I just want to take this opportunity to thank the Committee for helping Taiwan to improve the medical education. In fact before 2001 we didn't have an independent accreditation body.

Since the establishment of accreditation body called Taiwan Medical Accreditation Council, TMAC, we have substantially changed the performance of medical schools. We have a total 11 medical schools and through this kind of periodic review I think all the medical schools have been improving substantially in their quality of the medical education.

So last year we were thinking about the first cycle is all completed, and we started recognizing that there is still lots of room to improve, so in the report I submitted to the Committee is very much in a reflective mood and to put forward some goals that we'd like to achieve from now on, and that has been detailed in the staff analysis.

So I just want to thank you all for helping us in this aspect.

DR. DOCKERY: Are there any questions from members of the Committee before we go into Executive Session? All right. Would our guests please depart.

EXECUTIVE SESSION

END OF EXECUTIVE SESSION

DR. DOCKERY: Thank you very much. At this time, we will start with Grenada and ask Mr. James to please come forward. Good morning.

MR. JAMES: Good morning, Mr. Chairman. How are you?

DR. DOCKERY: Great.

MR. JAMES: Mr. Chairman, members of the committee, I will be presenting the report submitted by the country of Grenada, and you can find that report at Tab F.

Grenada utilizes the standards of the New York State Department of Education, Office of the Professions, to evaluate its one medical school located in the country. That is St. George's School of Medicine.

The country also uses the same standards to evaluate all of its clinical sites. In 2007, approximately $140 million in Federal student financial aid was awarded to students enrolled in postsecondary education programs within the country.

At the March 2007 meeting, the NCFMEA determined that Grenada's accreditation or approval process continued to be compatible to that used to evaluate medical schools in the United States. At that meeting, you requested that the country submit a report of its activities regarding its accreditation of the medical school within the country, and that report is the subject of this analysis.

The report noted that in April 2008 the New York State Department of Education's Office of Professions granted continued approval of the clinical sites used by the St. George's University School of Medicine within its state.

During the last year, 27 clinical sites were evaluated in three states, and 16

clinical sites were evaluated in the United Kingdom. A visit was also conducted at the school's administrative offices located in New York.

It was also reported that St. George's University School of Medicine began offering the first year of its basic science program to a university in the United Kingdom. Since this was a new program, a team of evaluators was sent to ensure that the University's science component was equivalent to that offered in Grenada. The team concluded that the course of study was, in fact, equivalent to that offered through St. George's University School of Medicine.

Regarding the changes of laws and regulations and its evaluation process and procedures, the report states that there are no changes.

Grenada reported that only one change was made to its current standards, and that was to include in its written standard the requirement for a clinical clerkship in

family practice.

The country also reported that in 2009 it will conduct site visits to clinical sites in five states, and will also conduct another second visit to the university located in the United Kingdom to reevaluate the science program, since it is a new program. They want to do a follow-up visit there.

At the spring 2007 NCFMEA meeting, you asked for updated information on two issues. First, you wanted further information on the country's requirement for a clerkship in family practice.

At that meeting, the country confirmed that, although it required this clerkship, this had not been established into its written guidelines, and the country responded by noting that the New York guidelines had been amended in 2007 to now require a rotation in family practice.

Second, it was noted that the country did not have a written conflicts of interest policy, and the committee requested

information regarding what conflict of interest policy was in existence.

The country responded by stating that it utilizes the New York State's conflicts of interest policy governing state employees. The country noted that this policy is utilized when conducting accrediting activities both within and without and outside of the state of New York.

In conclusion, the Department staff finds that the country has satisfactorily responded to the committee's requests. There are representatives from the country here to answer any questions, and that concludes my remarks, and I am now available to answer any questions.

DR. DOCKERY: Thanks, Mr. James. Are there questions for Mr. James before we ask representatives from Grenada to approach the table? All right.

Dr. Monahan, would you come forward, please, and I believe the Ambassador to Grenada is here also. She is not going to

be here? Thank you.

Good morning, and welcome.

DR. MONAHAN: Good morning, everyone. It is a pleasure to be here again.

I think Mr. James' analysis summarized everything pretty well. I would just follow up with a couple of comments.

One, there was a notation that in 2009 there will be site visits to a number of clinical sites that hadn't been visited before. We just completed those site visits in February and March.

In addition, a revisit to Northumbria will be conducted. My planning right now is either the last week of September or the first week of October.

In addition to that, I think that the two issues raised the last meeting dealing with the family practice clinical clerkship and the conflict of interest are being handled. The school is in the process now of developing a Department of Family Practice, and they are actively recruiting clinical

sites for the clerkships to be conducted at.

I would be glad to answer any questions.

DR. DOCKERY: Thank you. Are there questions from members of the Committee before we go into Executive Session? Hearing none, then would our guests please depart.

EXECUTIVE SESSION

END OF EXECUTIVE SESSION

Dr. Dockery: Next, we will take Hungary, after we ask our guests to please return. We welcome Dr. Rachael Shultz to make the presentation on Hungary.

DR. SHULTZ: Thank you. Good morning. I am Rachael Shultz. I will be presenting the information regarding Hungary's medical standards. The materials are located behind Tab F.

The Hungarian Accreditation Committee, or HAC, initially submitted Hungary's medical education accreditation standards for review by the NCFMEA in Spring 1997.

At its Spring 2003 meeting, the committee reaffirmed its prior determination that the standards and processes used by the HAC to evaluate its medical schools were comparable to those used to accredit schools in the United States.

To keep apprised of the accreditation activities of the HAC, the committee requested that Hungary submit a report on its accreditation activities for review at the Spring 2005 meeting. However, all NCFMEA meetings subsequent to the Fall 2004 meeting were suspended, and it was not until the Fall 2007 meeting, after the Secretary had appointed new committee members, that the NCFMEA had its first opportunity to review the HAC's accrediting activities.

An updated report presented at that time noted no concerns and was reviewed and accepted by the committee. The current redetermination is based upon information that the committed submitted in December 2008.

As has been the case when the

country has appeared before the committee in the past, there continue to be four medical schools in Hungary. All are based in state institutions of higher education and are fully accredited.

During 2007-2008, the most recent year for which figures are available, 25 American students received approximately $650,000 Title IV dollars to attend Hungarian schools.

Based upon the information provided, it appears that Hungary has an evaluation system that remains substantially comparable to that used to accredit medical schools in the United States. While the HAC has provided information regarding the country's quality assurance system for medical education in Hungary, four areas need to be further addressed.

These areas of concern were identified in the draft staff analysis. While Hungary did provide additional documentation regarding the four areas in its response to

the draft analysis, the documentation submitted was written in Hungarian and, therefore, staff was unable to evaluate it. As a result, additional information is still needed regarding the four issues.

The four areas of concern are related to: Part 2, Section 5.3, Medical Students. The country's higher education law does not appear to address the provision of health services, including mental health counseling, for its medical students.

The country responded that these services are covered in Section 22 of its Higher Education Act. Section 22 does require healthy and safe training conditions in educational settings. It also requires that the university provide services that contribute to a healthy lifestyle free of addictions.

Section 22 does not address the provision of health services, including mental health services, to students.

The response also references a

government decree that reportedly addresses these requirements. Again, this decree was not provided in English, so staff was unable to evaluate it.

Finally, the response also states that such services would be provided to students through the country's national health care system. However, it is unclear if such a system would cover non-Hungarian nationals studying in the country.

Part 2, Section 6.1, Resources for the Educational Program: The country's Higher Education law does not appear to address the necessity for facilities for the humane care of animals in teaching and research.

Part 3, Section 1, Site Visit: The country provided templates of the site visit evaluation and self-study requirements. However, it did not provide examples of actual self-studies or on-site evaluation visits.

In its response to the draft staff analysis, the country stated that actual self-studies or on-site evaluation reports may not

be released to third parties without the consent of the universities' presidents. Since no reports were provided, staff assumed that permission to view the reports was not granted. However, in a second response the country stated that it had actually not requested the evaluations, but was sure that they would be provided if requested.

ED's Foreign Schools -- The Department of Education's Foreign Schools team has expressed a concern regarding the monitoring of clinical sites used by Semmelweis University. In light of these concerns, it would be particularly helpful to have a copy of that particular institution's site visit evaluation.

It should be noted that schools participating in Title IV are obligated by regulation to supply this information as a condition of accepting Title IV funds, when requested by the Department. The schools may supply redacted copies in order to satisfy privacy concerns, but must provide the

requested information, translated into English, in response to this requirement.

Finally, Part 3, Section 3, Reevaluation and Monitoring: The country has stated that there is no ongoing accreditation monitoring by the HAC during the medical school's eight-year recognition period.

The most recent reviews were conducted by the HAC in 2005. Presumably, the schools will not receive their next HAC review until 2013. In the interim, the schools are expected to have internal controls in place to ensure ongoing program quality, rather than having the HAC, itself, go in.

Based upon its review of the material submitted by the HAC, Department staff concludes that Hungary has provided most of the information requested by the committee. However, as noted previously, there are still areas where additional information is needed.

There are country representatives present today, and I trust that they will provide clarification as to what was written

in the un-translated documents that were provided in response to the draft analysis.

I will also be happy to answer the committee's questions. Thank you.

DR. DOCKERY: Thank you, Dr. Shultz. Are there questions for Dr. Shultz before we ask the representatives from Hungary to approach the table?

Just one before they approach. Have you had any informal conversations with them about the lack of materials that have been supplied? Have there been any problems with understanding what we need in terms of making these determinations?

DR. SHULTZ: I haven't had any conversation with them, and I would add that their response was a little unusual, in that instead of supplying any rebuttal to what we had written as an analysis, they actually went in and rewrote my analysis for me, which of course, we could not accept.

Other than the rewritten analysis and the additional documentation that was in

Hungarian that, I'm sorry, I couldn't read, we have not had any more information.

DR. DOCKERY: Are there other questions before -- Dr. Hallock?

DR. HALLOCK: It just raises the question. Do we have the ability to get the Hungarian documents translated?

DR. SHULTZ: No. They need to be supplied in English.

DR. HALLOCK: Okay, thank you.

DR. DOCKERY: Thank you, Dr. Shultz. We will ask the representatives from Hungary that are present to please approach the table. Could I ask, please, for the record that you each introduce yourselves and use the microphone so that we can record the discussions.

PROF. MATER: My name is Klara Mater from the University of Debrecen. I am Professor of Anatomy and a member of the advisory board for the international education.

DR. KOVACS: My name is Gabor

Kovacs, Professor of Laboratory Medicine from the University of Pecs, and I represent here the Hungarian Education Committee, because I am the Chairman of the medical section of this committee.

MR. ERDEI: My name is Balazs Erdei. I am with the Hungarian Embassy, and I am responsible for science and technology.

DR. DOCKERY: Are there any comments that you would like to make before we go into Executive Session? Go ahead, sir.

DR. KOVACS: First of all, I would like to thank for the evaluation of our medical education system, and apologize for the -- what? -- for the quality of answer that our ministry gave to you, because I think they should have given the materials in English.

So coming to the comments of the committee, first is the insurance of the students. Every Hungarian medical student is insured by law. That means it is fully covered, including psychic disorders or any kind -- whatever disorders. The same holds

true for our foreign students coming from countries of the European Union. There are mutual agreements with the countries of the European Union.

It is different for the overseas students. They are not covered by law, and every -- all four medical schools have the regulation that, before they enroll these students, they should give them the chance to make their own insurance, and they do not enroll the students without any insurance, but they have to pay for that insurance themselves.

In addition, part of the problem, we have special organizations within the universities, partly run by the university administration, partly by the students of government, that care for the disabled students. We have special measures for physical disabled students, including transfer of them by special buses, or students with dyslexia and so forth.

So I believe that this issue is --

although not regulated in our higher education law, it is, in fact, functioning without any practical problems, at least in my eyes.

The second problem was the use of experimental animals in teaching. It is true, it is not regulated in our Higher Education Law, but it is regulated in another Act, an Act on animal protection in the use of experimental animals in teaching and experimentation.

All universities have a special committee on approving experimental animals in teaching or research. This includes the use of experimental animals, the ethical issues, and once they approve, then the researcher can submit this application to the local office of the Surgeon General, and this local office is entitled to give you a permit to use experimental animals.

This is controlled, and this permit usually lasts one or two years or, if you have a grant, it lasts usually to the end of your grant.

The third issue was the self-study requirements. Yes, during the accreditation process, our four medical schools prepare the self-studies. It is not -- There is no secret in the self-studies. It is quite a thick material, and I am a bit astonished that we -- that our ministry did not provide you with the English translation of this, because it is not publicized in any universities. It is not on the Web page of the university, but on request it is available, and it is also available, of course, at the Hungarian Accreditation Committee, because we did the analysis.

The eight-year accreditation period: Yes, it is regulated by law that Hungarian universities are accredited once in every eight years, but Hungary itself has realized that it is not sufficient.

Now we are in a transition. We are moving to an accreditation period of four or five years. It has not been decided yet, but it is submitted to the Parliament now, these two options, four or five years. But even if

you take this eight years' period, there are a lot of activities in between.

One of these activities is the so called parallel accreditation. That means that in mid-term period we decided to control all four medical schools by the same accreditation staff at the same time and make a comparison. We have finished that.

There are other controlled ways which are not -- well, you cannot call it accreditation, but contain a number of control elements regarding quality. One of these is the three years financing plan. The university signs a three years financing plan with the Minister of Education, and this three years period, they must report what they achieved or so, including quality.

There is an accreditation of the university capacity. So the Minister of Education must approve how many students you can enroll, and it is limited. You should not have more students than what quality requires.

In these eight years period, all

doctoral schools in Hungarian medical universities -- there are around 40 doctoral schools which are responsible for the PhD training -- are accredited by the Hungarian Accreditation Committee. It is not a complete accreditation, but the Ph.D. doctoral schools are accredited.

All universities must report any changes in the curriculum and get to the accreditation committee if there are changes. Another special aspect of the Hungarian accreditation is that universities are not entitled to appoint a new professor without the approval of the accreditation committee. So we have an opinion on every single new professor appointed in this period.

Finally, all four medical schools are ISO certified. They are certified according to the norms of ISO 901, and this describes how they should behave in the period between two accreditations.

Last, but not least, our department chairmen are appointed for four years. After

four years, they have to reapply for their jobs, and the Senate has to approve, and this is also a very strong quality control over the quality of teaching.

Concerning the site visits: If we talk about teaching hospitals, more than 95 percent of teaching goes on in hospitals which are part of the universities. We only have state-owned universities, and all our clinics are the same organization. They report to the university. Of course, the accreditation controls all these clinical sites.

We then have teaching hospitals outside of the university area. These are also site visited by the Hungarian Accreditation Committee. They usually are involved in -- some are practicals or clerk-ships of medical students.

The Semmelweis University in Budapest, which is the largest medical school in Hungary, has come up with a plan -- a new type of program. They decided to set up a second faculty in Germany, Hamburg, and this

staff, of course, is also under accreditation Phase 1 element, I must admit, which is not site visited, and these are the period of medical students. They spend a couple of weeks in western European universities during summer period or in the States, and for that we had no capacity for site visiting or -- well, western European universities. But these are short time visits that we accept.

Usually -- not usually -- it is mandatory that the Dean of the faculty make sure that the clinic the students are visiting is of a good quality, and they perform the program of the university. But it is not site visited by the Hungarian Committee of Accreditation.

Thank you. Maybe Professor Mater?

PROF. MATER: Yes. I would like to add. Okay. So I am from the University of Debrecen, and our medical education is accredited by the New York State and California State, and the New York State Educational Department asked our university to

have a teaching hospital, accredited teaching hospital, in New York State.

They made an agreement with the Wyckoff Medical Center in New York, Brooklyn, and the New York State Educational Department site visited this teaching hospital.

So our students, not only the international students but the Hungarian medical students, can spend 12 weeks as an internship in this Wyckoff Medical Center.

DR, DOCKERY: Thank you. Did your colleague want to make any comments?

MR. ERDEI: No.

DR. DOCKERY: Okay. Are there questions from the committee before we go into Executive Session? Then we will ask our guests to please depart.

EXECUTIVE SESSION

END OF EXECUTIVE SESSION

We can ask our guests to please return. Dr. Hallock?

DR. HALLOCK: A parenthetical for

the committee. We are probably going to see more Eastern European countries coming forward as the market for Americans increases. I wonder if at one of our next meetings we might have a review of what the Bologna Process brings and what the accreditation status is of Europe? I would be happy to help facilitate that, because there is no standard of accreditation. The standard has to do with the transferability of student credits. So maybe that would be helpful if we began to look at something like that.

DR. DOCKERY: Let the record note that we have placed that on the agenda for future consideration and, of course, it will be up to the committee and staff to decide on an appropriate time to consider that. Dr. Crane?

DR. CRANE: Mr. Chairman, may I ask a question perhaps of legal counsel with respect to Dr. Hallock's last question?

Is there any process that we have to specifically follow when we do make an

approval? Can it be done, as Dr. Hallock suggested, if they meet the requirements and staff feels that way, then we will accept it? In other words, it is a conditional acceptance based on staff's review, or does it have to be done in an open public meeting of this sort?

MS. WANNER: That is an interesting question that has just come up recently, and this committee can operate by con-call. You could do it by e-mail. It does not have to be a public meeting.

DR. DOCKERY: I would offer, though, I think that it is beneficial to the committee members to receive the information that they have requested, because it is quite detailed, and I think it is also a disservice to the accreditation process if we would have an informal process that would violate our more formal process that makes us more legitimate.

We will next review the country of Dominica, and invite Mr. Porcelli to come

before us.

MR. PORCELLI: Good morning. I am pleased to provide you with a brief summary of the periodic report submitted by the Medical Board of Dominica. The materials can be found under Tab C.

We first determined in 1997 and re-determined in 2001 and 2007 that the accreditation standards used by the Board to evaluate medical schools are comparable to the standards used in the United States.

During your last meeting, requested a report on the Board's accreditation activities during 2007-2008, a list of Board members' specific qualifications, and asked to be informed regarding the status and role of the proposed national accreditation body and its relationship to the Board and with Ross University School of Medicine.

The periodic report noted that the new All Saints University School of Medicine has opened on Dominica. However, that school is currently not certified by the Board. Ross

University remains the only Board certified medical school on Dominica.

The Department's records for the 2007-2008 academic year report that approximately 3300 students at Ross University received over $152 million in Federal financial assistance.

During the current reporting period, the Board conducted a comprehensive visit to Ross's Dominica campus and to its fifth semester program in Miami. The findings, including those from the clinical sites, are appended to the report.

During July 2008 Ross University informed the Board that it intended to open a site in Freeport, Grand Bahama, in January 2009. The Board conducted a preliminary review of the site in September 2008, and found that substantially more information was needed before the site could be found in compliance with the Board's requirements.

In addition, the Department received, late Friday, a copy of the site

report from the Board's March 1-3, 2009 visit to the Bahamas site. However, Department officials have determined that, as a legal matter, the NCFMEA's comparability determination regarding Dominica does not extend to the Board's activities with respect to basic science campuses outside Dominica, now to clinical sites in countries, such as the Bahamas, that are not currently determined comparable by the NCFMEA.

The Board also conducted a site visit to the campus of All Saints University School of Medicine in Dominica in May 2008. The site visitors considered their findings to be preliminary due to their significant concerns, the school's failure to provide all the requested information, and the fact that the school's clinical program and sites had not been visited. The school had not yet responded to the Board when the periodic report was submitted to the Department.

During the reporting period, new laws were passed to strengthen the authority

of the Board. Previously, the Board had its authority delegated to it by the Minister of Health and Social Security. Now the Board is directly responsible for the accreditation of the country's medical schools.

In addition, the country's medical schools are now specifically excluded from the authority of the new national accreditation body, which has authority over all other schools in Dominica.

The periodic report also noted that there have been no changes to the Board's standards and procedures since they were last reviewed by the NCFMEA in March 2007. In addition, the Board reported that it plans to visit approximately nine of Ross University's clinical sites in New York, New Jersey, and Connecticut during 2009.

Furthermore, the report included a brief outline of the specific qualifications possessed by each of the five members of the medical board, as requested. They all appear to be eminently qualified to perform their

assigned duties.

Based on its review of the documentation submitted by the Board, Department staff concludes that Dominica has provided all the requested information. Department staff also concludes that the Board's accreditation activities during the past reporting period appear to be consistent with NCFMEA guidelines.

Representatives of Dominica are here today to answer questions, and that concludes my remarks. Thank you.

DR. DOCKERY: Thank you. Are there questions of members of the Committee to Mr. Porcelli before we receive our guests? Dr. Hallock?

DR. HALLOCK: Thank you for that analysis. Take us just a little further with the legal matter that NCFMEA's activities don't go beyond Dominica in terms of the basic science or clinical campuses. What does that mean as we look at Freeport and some of these others? Does that mean they are off the table

for us?

MR. PORCELLI: That is my understanding, but I would like to let our legal counsel take that.

MS. WANNER: Yes. First of all, as far as clinical sites, the Department's position is that clinical sites are not eligible for the FFEL Program or now for the Direct Loan Program in a country other than where the school is located unless it is in a country that this committee has determined to be comparable.

So if at some future point Bahamas submitted a request for comparability, then it would become within this Board's purview to say, okay, these clinical sites of Ross are -- because the country is comparable, then we would in turn say that the clinical sites are eligible for the loan programs.

Now as far as the basic science campus, it is more difficult. We don't have any approval for a school that has half of its medical basic science program in one country

and half in another. So those students would simply be ineligible, and that is all I can say.

DR. DOCKERY: We have, though, had an approval for a basic science curriculum that was in Maine for one of our countries that we approved. In fact, I think St. Matthews had a main campus for some of their basic science, but it may have been another country.

DR. HALLOCK: But that is in the U.S., and it is considered comparable.

The issue then, Sally, is does that mean that any student who is in the Freeport campus would not be eligible, or the Freeport basic science campus would not be eligible for the FFEL Program?

MS. WANNER: That is correct.

DR. HALLOCK; But what happens if they mix -- and we need to probably come up with some guidance, because what we don't want to have is them admitting kids to either Dominica or Freeport and then saying, well,

you can do the first six months here, but skip over to take anatomy somewhere else, or whatever.

I think that the implication of what you are saying is that, if a student were to go to Freeport, they would become ineligible for the program.

MS. WANNER: Well, the school would certainly have to advise them that they couldn't take out loans for that purpose, and the school would be liable if they certified loans for that campus.

DR. DOCKERY: Dr. Munoz.

DR. MUNOZ: I am not sure that we have, for the schools that we have approved, then fully comprehended all of the clinical sites that they use. So, for example, in the previous discussion where Hungary was talking about sometimes it has short rotations in other European countries, not all of which have been deemed comparable to the U.S.

So that if, for example, someone did a rotation in France which is not deemed

comparable, or another country, to what extent do we as a Department or as a committee have to review all of the potential sites that might be used?

There are some that are obviously official and used by a school as part of its curriculum. There are others that are unofficial where students may elect to take a rotation for short periods of time elsewhere, and to what extent are we required to review those?

MS WANNER: My understanding was that those weren't clinical sites. That was my understanding, that they were just sort of electives, that you could complete your medical program without doing those. You know, in that case it is neither here nor there, but I am not certain either that they were outside of countries we determine comparable. However, Federal Student Aid when they certify schools, they ask where are your clinical sites, and that is the entity that we certify.

DR. DOCKERY: Dr. Wentz.

DR. WENTZ: I think Dr. Munoz has somewhat addressed the question I had, but I am still confused. If the medical school is accredited by the Dominica Medical Board and then makes these arrangements, maybe this is something we should do in an Executive Session, but I am little confused about separating these sites since the accreditation authority was clear through the Dominica Medical Board.

DR. DOCKERY: Mr. La Porte.

MR. LA PORTE: Yes. I am also having trouble wrapping my brain around this, because we approved the accreditation process, and if the accreditation process has the authority to look at other countries, it is kind of moot whether that country has been accepted by us.

What if the clinical site was, you know, just theoretically, in international waters where there was no country? To me, it is not -- it does not make sense. It is not

rational why this is the policy.

DR. DOCKERY: Thank you. We would invite our guests to come to the table. Dr. Shillingford, it is always good to see you, and Mr. Michaelson. Good morning, sirs. We would invite you to make any comments before we go into Executive Session.

DR. SHILLINGFORD: I would like to thank the Chairman and members of the Board for having us here. I certainly look forward to meeting with you when we do have an opportunity to present our report as I realize, in a way, that this is not just a question of looking at the standards, but also of assisting the Dominica Medical Board as well as the school to improve the quality of education as we go through what is required for -- you know, what are the procedures one should follow for the accreditation of the medical school.

I would also like to thank Mr. Porcelli and the readers for the effort they have put into it by reading the voluminous

documents which we have provided you in order for you to appreciate the robustness by which the Medical Board goes through the accreditation process, and I must say that I was very pleased at the excellent report provided by Mr. Porcelli.

I think this is about as much as I could say at this particular stage of the meeting, unless you have any questions.

DR. DOCKERY: Mr. Michaelson, do you have any comments to make?

MR. MICHAELSON: No, sir.

DR. DOCKERY: Are there questions from the Committee before we go into Executive Session? If we could ask our guests to depart once again, please.

EXECUTIVE SESSION

END OF EXECUTIVE SESSION

DR. DOCKERY: Let me have the will of the committee express itself. We have the opportunity of hearing the Philippines, who do not have a representative here, and we would adjourn for lunch at 12:15. We are on time.

We can go ahead and adjourn now, have bathroom breaks, and prepare for lunch, and reconstitute at 1:15. So what is your pleasure? Philippines?

I think Philippines have it. So let us start with inviting Mr. Mula to come, and we will welcome you back this afternoon, Mr. James. Thank you.

So now we are going to take the Philippines, and Mr. Mula, do you want to make your remarks?

MR. MULA: Good morning, Mr. Chair and members of the National Committee. I will be presenting a brief summary of the report submitted by the Philippine Accrediting Association of Schools, Colleges and Universities, Commission on Medical Education, hereinafter referred to as Commission. The material can be found at Tab I.

The most recent data available, which is dated 2007 and 2008, tells us that there are approximately 12 students in the country receiving $173,250 in Federal student

aid monies.

In March 2004, you received a comprehensive report from the country and determined that the Philippines had in operation a system for the evaluation and accreditation of medical schools that was comparable to the system used in the United States, and that the Philippines accrediting Association of Schools, Colleges and Universities, Commission on Medical Education was the designated body that is responsible for the evaluation of the quality of medical education within the country.

You also asked for a report of the Commission's accreditation activities from 2004 to 2005.

Since the NCFMEA did not meet in September 2006 to consider the report requested at your March 2004 meeting, that report, which includes activities from 2005 through 2007, was received and accepted at your September 2007 meeting.

The report before you now covers

the Commission's accrediting activities from September 2007 through December 2008. It includes the status of the country's medical schools and an overview of its accreditation activities, to include a schedule of upcoming accreditation activities through 2009.

It also affirms that there have been no changes in the country's laws and regulations or the standards, processes and procedures used by the Commission in the implementation of its accreditation activities.

Department staff concludes that the country has satisfactorily responded to the Secretary's request for information, and that there are no substantial changes of the standards or processes that the National Committee determined to be comparable in March 2004. Department staff also concludes that the country's accreditation activities during that period appear to be consistent with this committee's guidelines.

This concludes my presentation.

There are no members from the country here present at the meeting, and I will be glad to answer any questions you might have.

DR. DOCKERY: Thank you very much. Are there any questions for Mr. Mula before we go into Executive Session? We could ask our guests to depart, please.

EXECUTIVE SESSION

END OF EXECUTIVE SESSION

We will reconvene at 12:15 for lunch. Serve yourselves, and we will have lunch in place and hear from Dr. Nasca.

(Whereupon, the foregoing matter went off the record at 11:53 a.m.) - - -

A F T E R N O O N S E S S I O N

12:22 p.m.

DR. DOCKERY: In the interest of being on time and courtesy to our guests, we would like to go ahead and get started, and to thank Dr. Thomas Nasca for agreeing to come and speak with us.

Dr. Nasca is the Chief Executive Officer of the Accreditation Council for

Graduate Medical Education. As you all know, the ACGME is a very important organization to the NCFMEA in regard to the provision of accredited residency training programs.

In advance of Dr. Nasca's presentation, I would like to tell you that I have already told him that we work for the government, and we apologize for our spartan environment. Dr. Nasca brought his own computer and his own technological cook-ups. So he is supplying everything for this presentation, including his transportation here and back. So, hopefully, he will get back safely.

Dr. Nasca, thank you so much for coming and being with us.

DR. NASCA: Thank you very much. Well, it is certainly a pleasure to be here with you. I was not exactly clear how well you understood the specific nature of the ACGME. So if I give you information that you already know, please just give me a signal -- Dr. Hallock is very good at giving me signals

-- and we will move on to the next topic.

What I would like to do is tell you a little bit about the ACGME, and then maybe we could have a discussion on the impact of accreditation on graduate medical education.

I am going to give you an overview of the kinds of impacts we are attempting to have and talk to you a little bit about the use of accreditation structures as a lever to move the educational system in the United States, and then talk a little bit about the structure, because it is my understanding -- and if this wrong, we can skip that part -- that the alphabet soup of American organizations can sometimes be confusing to those uninitiated.

I have only one disclosure, and that is the ACGME actually does pay me, but other than that, I have no other disclosures. I don't own stock in anything to speak of, certainly anything that is worth anything, certainly nothing associated with medicine.

I think it is important to

recognize that there is a legacy of graduate medical education in the United States, and we sometimes have the mistaken perspective that it was always there. It really wasn't always there, and if you go around the world, you can actually see countries in various stages of development that we have gone through over the last 60 or 70 years.

Graduate medical education in the United States has evolved into a required component of the continuum rather than an optional component of the continuum in medical education. We have evolved into production of highly trained specialists and subspecialists, and we provide the clinical workforce for the United States.

Now the ACGME is an interesting entity. It has evolved over the last 60 years. It is really the embodiment of de Tocqueville's and Franklin's vision of private entities serving the public good, and it is a 501(c)(3) not-for-profit corporation. I will tell you a little bit more about that in a

second.

It is really the meeting place of the thought leaders in American graduate medical education. The members of the Board of the ACGME are nominated by at least five organizations which, you can see, are the umbrella organizations of the United States involved in either medical education, the certification of specialists, or the receiving organizations, the American Hospital Association, the American Medical Association, and the Council of Medical Specialty Societies.

Then at the Residency Review Committee level, the specific specialty level, we have three organizations that nominate individuals who volunteer to serve on those committees, the AMA, the respective Board and the respective college or academy from the specialty specific entity.

So you can see, the ACGME really is the framework for the profession coming together to do its work to create and accredit

the educational programs that sustain the profession over time.

Now the ACGME has evolved from independent individual specialty review committees through a council within the AMA, in the year 2000 spun off as an independent 501(c)(3) corporation, and its mission is the advancement of the health of the citizens of the United States through enhancement in graduate medical education.

I will add parenthetically that "the citizens of the United States" was added by me just for the purposes of this presentation. It is not actually part of the mission statement. It is just "the advancement of health through enhancement of graduate medical education."

The authority of the review committees is delegated by the Board to each committee. In other words, each residency review committee has no authority to accredit on its own. It is delegated from the Board of the ACGME to each specialty committee, and the

ACGME is responsible then -- that is, the ACGME Board is responsible to the public for the oversight of the work of each of these committees, and we have an extensive process that allows that to happen.

Now the Board of Directors of the ACGME are selected. There are four individuals selected from slates that are nominated by five member organizations, those five that I showed you. There are two resident members, three public members, and the Chair of the Council of Review Committee Chairs. In other words, all of the chairs of the review committees, the 28 review committees, sit together and they elect a Chair, and that Chair sits on the Board.

The Chair of the ACGME can be supernumeratedly elected by merit from the members of the Board, and I sit on the Board as Secretary of the Board without vote by virtue of being the CEO.

Now the ACGME believes very strongly that the output of our work produces

a social good, and that is that we produce individuals who provide patient care, basic and clinical research, education of the future physicians and other health care professionals, and provide community service beyond the clinical care that we provide.

We do believe very strongly that patient care is improved through education of the next generation of physicians, and that is not only patient care in the future. It is patient care in the present.

Now I am just going to try and give you some idea of the complexity of the relationships within the ACGME. Each of us, depending on our specialty, views the ACGME in this fashion. There is a specialty review committee -- in my case, for instance, internal medicine -- and there is a Board of Directors of the Accreditation Council, and there is an interchange between these two entities.

There is an Executive Committee of the Board. About 10 years ago, an

Institutional Review Committee was added to the mix. So that, in addition to adjudicating the effectiveness of implementation of the standards of each specialty within an institution, the institution itself is reviewed.

We have a series of committees that interface with the review committees. The Monitoring Committee is the committee that is charged with overseeing the work of the review committees.

In other words, every five years at a minimum, and sometimes more frequently, each residency review committee must submit a report to the Monitoring Committee, and the Monitoring Committee judges their effectiveness of accreditation and their consistency, and then they render citations or deficiencies, and they render an accreditation cycle or delegated authority to accredit cycle that can be anywhere between one and five years, very much the way we accredit residency programs.

There is a Program Requirements Committee that reviews the proposed specialty specific requirements, and then for appeals when an institution is not happy with the decision that they receive, if it is an adverse decision, they can appeal it.

Obviously, there are a whole series of other committees of the Board that support the work of any not for profit 501(c)(3) corporation.

The complexity comes, because there are 28 committees. There are not just a couple, and the relationships then are governed very strictly by policies and procedures.

The reason for that is twofold. The first is there would be chaos without policies and procedures that were rigorously applied. The second is that it is very important for every program and every program director to know the rules, and the rules are not only the standards. The rules are also how we interrelate and how we enforce those

standards, the policies and procedures.

As I mentioned, there is a Council of Review Committee Chairs that is the interface between the Board and the committees, and that work of that interface is very, very important in making sure, first of all, that the Board is understanding of the challenges that these committees are facing, and these committees understand the intentions and needs of the Board.

Just one other parenthetical remark: We are adding a peer review journal. That journal will publish its first issue in September of this year, and have added a Journal Oversight Committee.

Now the Board has approved a set of values, and these values look very much like many of our institutional values, with a couple of additions.

Obviously, the values are: Professionalism, as articulated in honesty and integrity and excellence in innovation; accountability and transparency, what you

would expect for an accrediting body; fairness and equity, absolutely essential, because if we cannot instill and maintain the trust of our colleagues in each one of our teaching programs that we won't have the opportunity to accredit; and then we have a stewardship responsibility.

The only source of revenue for the ACGME are accreditation fees, and so we must be good stewards of that largess. Then, obviously, engagement of the stakeholders. If you are going to lead an educational enterprise, there needs to be engagement of those who are actually accomplishing the education in order to do this well.

Now there are a whole series of accreditation goals. First and foremost is to assure the safety and excellence of patient care in the teaching setting; to create excellence in the graduate program, and we take that very seriously, and hence the move toward outcomes and outcomes based accreditation.

Our goal is to standardize to some degree -- we would never standardize completely the clinical and educational experience and outcomes of trainees in disciplines across a jurisdiction, but we do hope, to some degree, to create some homogeneity in the output.

In order to accomplish the above, the really have to assure effective evaluation of the trainees. We have to assure that the trainees learn in humanistic and reasonable settings, obviously anything from duty hours to service versus education issues related to that bullet. Then we have to coordinate the requirements for programs with the required experiences of the trainees for certification.

So we need to make sure that we work in concert with the boards or at least understand when there are difference between our standards and boards' standards, because obviously, the goal is to produce individuals who become board certified in their specialty.

Now I probably don't need to point

this out to you as an overseer of accreditors. But obviously, there is a significant difference accreditation and certification in the context of graduate medical education.

The accrediting body for programs sets accreditation standards and assesses compliance with those standards; whereas, the certifying bodies -- those are the ABMS boards in our situation -- set benchmarks for recognition of individuals, and then assess the individual's level of achievement in comparison to that benchmark.

Now -- and please, if this is information that you already know, please let me know. But there are a number of organizations that oversee the continuum of formal medical education in the United States, and you heard about five of them when it comes to the ACGME.

The AMA, the AAMC, the American Hospital Association, American Board of Medical Specialties, and Council of Medical Specialty Societies are involved in the

continuum, obviously. The AMA and AAMC specifically oversee medical student education in the United States, and that is overseen by the U.S. Department of Education.

The ACGME gets its membership from these five organizations and oversees the graduate phase of medical education. Then the Federation of State Medical Licensing Boards, the National Board of Medical Examiners and the ECFMG oversee key steps in the licensing process in the form of both the USMLE medical knowledge exams and the clinical skills examination. Then finally, recognition of the specialists is by the ABMS at the specialty board level.

So you can see that we have organizations -- those are the shaded ones -- that are involved in both individual recognition, as well as on the part of the ABMS, program specific accreditation.

Now the philosophy that I was talking about as we attempt to introduce trends into graduate medical education that

bring out excellence in outcomes of our trainees is summarized in this sort of a tension that is brought about by what I am going to tell you next.

If we look at an accrediting body, it is very unusual for an accrediting body to have as a mission to drive innovation. In general, accrediting bodies function as trailing edge phenomena.

In other words, the majority of institutions or programs provide education in a certain fashion and, when they provide education in that certain fashion for long enough, if it is shown to be of benefit, that fashion of education then is incorporated into the accreditation standards, that so called trailing edge.

It is in the community. Eighty percent of programs already do it, and you get the 20 percent of programs that are not doing it to do it well by introducing a standard.

That is different than a conceptual framework of a leading edge kind of a

standard. A leading edge standard is a standard that is introduced to drive the profession or the educational programs in a particular direction.

Over the course of the last 15 years, the ACGME has gradually moved from trailing edge standards to leading edge standards. What would be examples of those leading edge standards? The competencies would be a classic example, as would resident duty hours standards would be examples of leading edge standards.

Now the other important dimension here that is the same in both of these boxes is the method of assessing compliance is a substantial compliance model where the program is judged to be in substantial compliance if the vast majority of the rules are satisfied, and where deficiencies are identified, they are rectifiable or are not lethal kinds of deficiencies in the educational program.

Of late, the -- Well, let me take a step back. One of our leading edge standards

that has caused considerable discussion in the United States has been the discussion around resident duty hour standards.

The duty hour standards were introduced in 2003, and the enforcement model was a substantial compliance model with a set point very similar to the accreditation of the rest of the standards around substantial compliance model.

Now those of you who had the chance to read the Institute of Medicine report and hear the criticisms in the public of the ACGME, this is the basis of that disagreement.

The expectation of some in the society is that we be dealing with leading edge duty hour standards that have regulatory adherence as opposed to substantial compliance as the judge of compliance. Let me say that again.

There is this expectation that the duty hour standards not be treated as educational accreditation standards and judged by substantial compliance with those

standards. There is the expectation that they be considered regulation and that the ACGME assess compliance by regulatory adherence -- in other words, a zero tolerance for violation model.

If you read the medical literature, you will notice that the ACGME, using a substantial compliance model, assesses that there are about eight percent of programs that have duty hours violations that cross the threshold of substantial compliance violation. In other words, they do not reach the threshold of substantial compliance.

Whereas, if you read someone like Landrigan, who has done studies with interns in pediatrics and other specialties, he assesses that deficiency at somewhere around 60-70 percent of programs, because his standard of violation in one intern saying that one time they work rated at 80 hours or stayed more than 30 hours.

So there is a dichotomy, and the IOM is driving toward this set of

expectations, and hence the conflict between the ACGME and the public sector.

Now where is the ACGME trying to drive the profession? Well, I am going to give you some information that you all know, but try and give it to you graphically, quickly, so that we can frame the discussion.

That is that all of us remember that the structure of our educational programs are based on this particular model. That is graded or progressive responsibility. In other words, we start out in physical diagnosis with a very high degree of supervision and absolutely no authority in decision making.

Then we move through the continuum of medical education with greater degrees of authority and decision making and lower degrees of supervision, ultimately ending up as an attending with no direct supervision, more distant supervision from a quality perspective, and absolute authority in decision making.

Now David Leach, my predecessor, introduced into our lexicon in medical education the Dreyfus conceptual model of the development of mastery, and with the student beginning as a novice, not knowing what they don't know, and some of us were fortunate enough progressing to mastery.

So graphically we can look at it in this fashion. We have this conceptual framework on the Y axis of starting from a novice and then moving all the way to master, and then starting in undergraduate medical education as a novice and then moving into graduate medical education, the phase that we are talking about today, somewhere as an advanced beginner to competent, and then moving to proficiency, and then in clinical practice maintaining at least proficiency, some going on to expert status, and even fewer going on to mastery. That is the conceptual framework.

What we talk about now is this graduate phase. What I would like to do is

maybe peel the onion for you. You know, we have these six domains of clinical competency, probably soon to be seven with technical proficiency being a separate seventh category or competency. That will probably be approved by ABMS and ACGME over the next year.

If we think conceptually, say, about a three-year residency program, we would start out as an advanced beginner, but is it really that simple? It probably isn't.

It may well be that, say, in internal medicine or pediatrics that we would believe that they would start out as an advanced beginner. They sort of know how to do a complete history or physical, but they don't really know how to develop a good differential diagnosis yet and the like. So they are really not competent yet.

Over the course of the PGY1 year, we would expect that they would move to competency and then proficiency by the end of the PGY2 year, and then refine that and enhance that.

Now would we have the same expectation for systems based practice? Probably not, because if they didn't train in your institution, they don't know your systems.

So they would start off as a novice in your institution, and then assume to move very quickly in the PGY1 year to a competent level, because otherwise they wouldn't get their work done, and we have all seen interns who have been in that category, who can't really figure out how to get the work done.

Now I would ask you the question: How many of you want an advanced beginner when it comes to professionalism as an intern? You probably want a more developed set of professional behaviors than an advanced beginner for your first year house officer. So you have an expectation that they would start at a different level.

What I would posit to you is that in each one of our specialties, these are milestones. These are expectations that we

have of house officers of levels of performance, and those levels of performance in key areas should be common across all programs, and this is really the outcomes project, is figuring out how do we go from this conceptual framework where we track a house officer.

They deteriorate in their performance in this case with regard to patient care capabilities, and then we rectify them with information based on where we think they should be, not based on the individual program director's gut feeling about where they should be or the program's culture about where they should be, but really on national standards or national expectations.

Then ultimately, these final milestones or expectations, as they are articulated, become the entry into the initial phase of a certification process. So we need to be sure that, as each specialty articulates these, that the Board agrees with them.

Now it is the same for surgical

discipline as well. If you look at surgical skills, they may well project from advanced beginner all the way through in this envelope, but surgical training is different than nonoperative surgical training, is loaded to a great degree to the front.

Systems based practice -- again, if you haven't worked in that particular OR, you don't understand how it works, but you may have greater expectations with regard to nonoperative patient care based on the structure of, for instance in this case, general surgery.

So we need to really understand the expectations. We have three specialties now that are in the process of determining these milestones. Internal medicine, pediatrics, and general surgery are in the process of defining these milestones across the six domains of clinical competency.

We hope eventually to be able to do this in all specialties so that we can rectify those deficiencies and be sure that each

trainee then does enter practice or completes graduate medical education at the level of at least proficiency and be able to certify that to the public.

Now let me switch gears a little bit here. When we look internationally at prototypes of systems of accreditation and oversight of graduate medical education programs, which is different than what you look at, we see that there are three models.

The first model is the government oversight model, which is a ministry of health model, in some cases a ministry of education, but that is more frequently at the undergraduate level than it is at the post graduate level, and in most countries it is called post graduate training.

There is the self-regulation model. In other words, the profession is self-regulating, and the two models would be -- The one that predominates internationally right now is the Royal College model or the representational organizational model, where

the college also accredits and also certifies in many circumstances.

Licensure in those countries may or may not be present. There are many countries where there is no such thing as formal licensure, and it is really the college activities that determine whether you are entered into the practice of medicine.

Then we have the U.S. system of professional self-regulation, and in this system there is corporate separation of accreditation and certification functions, and licensure is a third dimension. That is local, as you are well aware, and is a state governmental function, not a Federal function.

Then interestingly, in most of the world there is a nonregulatory model. In other words, in most of the world, if you counted countries, most countries would have no formal structure or oversight of post graduate training.

Now to give you some frame of reference for the U.S. system of the ACGME --

and I would add that these numbers do not include osteopathic training. That is governed by a separate body, the American Osteopathic Association.

So to look at the full portfolio of postgraduate training that is accredited, you would need to look at AOA, which is much smaller than this, but it has some number of programs and trainees.

We have 8,696 programs accredited as we speak in 692 sponsoring institutions. We have almost 3,000 teaching hospitals or institutions that participate in residency training in the United States, and we have over 111,000 residents and fellows currently enrolled in ACGME accredited residencies and fellowships.

The ACGME itself does its work with about 365 volunteers, physician volunteers, and about, right now, 162 full time administrative staff.

Now if you look at the economic impact, the Medicare reimbursement for GME in

the United States is about $10 billion, which on average is $93,000 per resident. The ACGME expense budget is $32 million, which is less than .3 percent of total Medicare GME expenditures or about $280 per resident per year.

Now what is the impact of accreditation in the United States? Well, we believe we have been continuously raising standards, and actually we can demonstrate that, if you look at -- track specialty standards over the years. Every specialty has raised standards and promoted excellence in many institutions that otherwise would not have been very good.

Parenthetically, I will give you an example. In the state of New Jersey in the 1980s, there was not one internal medicine program that had an American Board of Internal Medicine pass rate greater than 50 percent. Today there is not a single program in the state of New Jersey who has a Board pass rate less than 90 percent, which is five points

above the national average.

The reason for that is that in 1987 the Internal Medicine Residency Review Committee put in a standard with regard to board passage rate, and lo and behold, everyone's performance improved.

So we can give you many, many examples. That is just one example of where the changes in standards resulted in improvement in outcomes, measurable outcomes.

We have introduced physician competencies into American medicine. I mean, that really came from the ACGME. We are developing the milestones of training, and we have enhanced the learning environment, including resident duty hours and resident wellbeing.

Then finally, I can tell you with confidence that the care in the United States in teaching hospitals, the outcomes of care as well as the processes of care are better than in non-teaching hospitals.

There are any number of reviews,

and I will tell you, the reason these reviews were done had nothing to do with education. The reason these reviews were done was because it costs more in teaching hospitals than non-teaching hospitals.

So there were many people interested in demonstrating that care was not better in teaching hospitals than non-teaching hospitals, but it turns out that in every situation where meta-analyses have been done and reviews have been done of studies, with one exception teaching hospitals provide better care than non-teaching hospitals, as measured by outcomes as well as process.

The one exception is in some studies looking at neonatal intensive care units in community hospitals, non-teaching community hospitals versus academic medical centers.

There are many confounding variables in those studies, and they continue to look at that, but that is the only setting where it has not been demonstrated that

teaching hospitals are categorically superior.

Now I could go on and talk about the pipeline, if you want, but I will stop here and answer questions, if that is what your pleasure would be.

DR. DOCKERY: Thank you, Dr. Nasca. It might be helpful to have a few words about pipeline, because we are dealing with that through many issues. So I think we would benefit from that, if you have the time.

DR. NASCA: I always have slides. I'm a nephrologist. I have graphs, too. So now I'm in heaven.

This is a graphic that Ed Salsberg gave to me a year ago. So it is a little bit out of date, but the numbers really haven't changed very significantly.

What this shows is that back in 2002-2003 Jody Cohen called for expansion of U.S. allopathic medical school output by 30 percent, and you see the response of the community. This is first year enrollment, very similar to output numbers just with a

time lag of four years.

What you see is that existing schools are projected to expand over the next decade, and with the addition of new schools, by around 2015 we are projecting around 21,000 graduates and plateauing, I think -- Jim, is it about 2022 at around 22,500 graduates. Okay? So remember that number.

This is the striking one, though, to me. If you look at allopathic expansion, by 2013 we will be at about 20,000, but remember, the curve is upward.

This is the most striking one. If you look at this number back in 1992, 10 years before this, this number was 1800, and in about 20 years it will have almost tripled. So you can see that the osteopathic output has dramatically increased.

So in 2013 it is expected we would have about 25,000 onshore graduates as opposed to 19,500 in 2002. So now remember this number, 25,100.

Now everyone, when they start to

look into this, gets a sense of comfort in the fact that the total number of accredited entities accredited by the ACGME continues to increase. So you've seen a fairly significant increase in the number of residency training programs accredited by the ACGME.

This is the data from 2003 to 2008, and we went from less than 8,000 in 2003 to, in 2007-2008, about 8400; and as I just told you, we are almost at 8700. So you can see that that slope continues. Right?

Here is the problem. There has been almost no increase in residency positions. It has all been in fellowship positions. This is accredited positions -- accredited programs, pardon me.

This increase is somewhat artifactual. This, in some sense, is artifactual, because it represents the accreditation of medicine/pediatrics combined training programs who were previously not accredited, but the trainees were there.

They were just part of -- counted

as part of either pediatrics or medicine in existing, accredited medicine and pediatrics programs. So this 1.5 percent increase is even artificially inflated.

Now if you take the pipeline positions -- and by pipeline -- you know, we always have to be worried about definitions. You can see the specialties that we listed here. These specialties are the specialties that we accredit that lead to initial board certification.

So for instance, you would say, well, colon and rectal surgery is a separate RRC. Yes, it is a separate RRC, but it is really a fellowship program, because you must complete five years of general surgery before you can enter a colon-rectal surgery -- what is called a residency, but it is really a fellowship.

So you need to recognize those nuances. So if you look at this as the pipeline, there is an additional phenomenon that you need to recognize in counting the

numbers.

If we look at the GY-1 positions -- in other words, the first year of specialty training in each of these disciplines. So in anesthesiology, that would be a PGY-2, right? You can see that the total number of positions in 2007-2008 was about 25,800. But the number of positions that were available to first year residents who had no previous GME experience was only 24,000.

So that defines the real pipeline for people who are coming in de novo into the GME system. It is 24,000. So what we -- if you remember that number that I showed you, in 2013 matriculating onshore students will be 25,100. Even if we have an attrition, they are not going to lose that percentage. They are not going to lose more than four or five percent.

So we are looking at around 2015 to 2017 when these lines are going to cross. In other words, if we project out, even if we projected out a 1.5 percent growth in the

pipeline which, I will tell you, hospital CEO say will not happen, because they don't see any reason to expand their residency positions -- What we see is, if we project Ed Salsberg's line on there, you can see that those lines start to come together around 2013, and they cross around 2015 to 2017, not shown on the graph.

So we are heading for trouble, and I am not going to say anything more about this than that, and then entertain questions, because there are certain constraints that I have coming from the accrediting body around manpower.

DR. DOCKERY: Thank you very much, Dr. Nasca. That was a delightful and informative presentation, and we will even applaud now.

(Applause)

Are there questions from the committee? It is very timely, particularly, that you come today, because we have been charged with the responsibility of writing a

report to Congress on the requirements for certain schools that have been exempt from certain criteria in advance, and trying to predict their access to accredited residency training programs.

What we have discovered is validated in your slides, and I am glad that you went ahead with the pipeline.

Dr. Hallock?

DR. HALLOCK: Maybe just for context, the 11,000 total trainees you put there, roughly 25 percent are IMGs.

DR. NASCA: Yes.

DR. HALLOCK: So that would be 25,000. Of that group, 20 percent are U.S. IMGs, which is really vital for this group. So in training, there are probably 5,000 to 6,000 U.S. citizens, IMGs, coming out of the system that we talk about, just to give everybody that perspective.

So as Dr. Nasca showed you these numbers changing, the availability of spots for IMGs and for the U.S. IMGs begins to be a

part of that pinch that he demonstrated.

DR. REGAN: Excuse me. I have a question on the slide right before that where you had the two lines. Can you go back to that?

I see you have a line, and at the very end you added in the total estimated increase in allopathic and osteopathic graduates, but the line that you first started with -- wasn't it only allopathic? So did you actually increase -- So you added -- So it is cumulative?

DR. NASCA: Yes. You can see, the number is approaching 25,000 in 2013 there. Let me go back, and I will show you where that comes from. Right there.

DR. REGAN: Okay. I knew you had separated them out, and then I didn't know if you were cumulative at the end. Okay. Thank you.

DR. DOCKERY: Other questions?

DR. MALDONADO: Are there any specialties, primary specialties, that are

losing positions and accreditations overall?

DR. NASCA: Yes. Well, accredited versus occupied, because there are clearly specialties over that five-year period of time that had a downward trajectory in occupied positions, not accredited positions.

Thoracic surgery would be one of them, dramatically down. Medical genetics would be a second. A third would be down but only slightly down, is general surgery. So there a number of specialties that have a downward trajectory in occupied positions.

I didn't talk about occupancy rates of accredited positions, which is another dimension to this whole issue, because the number of vacant GME positions that are accredited in the United States has dropped dramatically over the last five year, and that is before this big influx of onshore graduates really hits the pavement.

DR. DOCKERY: What has been the success of the encouragement to the effort to grow more primary care accredited residency

and training positions and to encourage people to enter primary care?

One of the reasons that I ask that question, too, is the impact of the student debt that influences specialty choices.

DR. NASCA: Well, there are no deficiency in primary care positions in the United States. So the issue is not accredited positions. The issue in family medicine is it is applicants in internal medicine and, to a lesser extent, pediatrics. It is the specialty choice at the end. It is the subspecialization after core residency in those disciplines.

OB/GYN is pretty stable. Hasn't gone up dramatically, hasn't gone down at all, really. It is up slightly, if you consider that a primary care discipline.

So the barrier to U.S. graduates choosing primary care is not availability of accredited residency programs.

DR. DOCKERY: And is OB/GYN the only specialty that does their own

accreditation? Their special requirements are approved by the ACGME, but they have their own accreditation process.

DR. NASCA: Only for two subspecialties. I guess it's -- It is not their core residency. Their core residency --

DR. DOCKERY: Reproductive endocrinology and --

DR. NASCA: -- MFM, maternal fetal medicine, and there is discussion about that stopping.

DR. DOCKERY: Other questions? Dr. Shah.

DR. SHAH: How do the international medical graduates fit into the pipeline, because I don't think you included that one in there. Correct?

DR. NASCA: Well, by implication -- If one makes the assumption that the majority of the positions will first go to U.S. graduates, the implication is that international graduates will be crowded out.

Now that is not a given, and it is

not 100 percent. So what I actually believe will happen is that somewhere around 2011-2012 we will start to see some U.S. graduates from the bottom of the class not get residency positions, because there will be very highly competitive international graduates who will be seen as more desirable than some of those graduates.

We have seen that in a microcosm on occasion in the past, but I think we will start to see that long before the lines cross.

DR. DOCKERY: Dr. Regan?

DR. REGAN: And what is the medical community doing to address this issue? They are looking forward to increasing anymore slots?

DR. NASCA: The issue -- This is really a governmental issue. This is all driven by government funding. There has been a cap on the number of residency positions since 1997, and until that cap is lifted, you will not see -- I don't believe you will see -- and I am not controlling this. This is

individual hospital decisions about whether they either start or expand residency positions.

The reason that fellowship positions continue to expand in the absence of specific funding for them is because, at an institutional level, there are benefits to having fellowships.

Most of the fellowship numbers we are seeing are in new subspecialties, clinical cardiac electrophysiology, interventional cardiology, sleep medicine, palliative care. All of these are new subspecialties that have been introduced that are on the end of the pipeline. They don't increase the diameter of the pipeline.

They provide a programmatic advantage to the institution. So they are willing to front the dollars to support these trainees; whereas, for core residency positions there is less of an economic benefit.

The other factor is that many of

our primary care residencies or pipeline residencies are at or near their maximum size in each of the institutions that are currently active. They don't have the capacity to expand. So we would really be talking about putting on new institutions.

MS. LEWIS: Dr. Nasca, do you know the status of the regulation proposed by the Center for Medicare/Medicaid Services in 2007 that would eliminate the Medicare funding for GME positions in the U.S.?

DR. NASCA: Well, there have been numerous different kinds of approaches. You know, MedPAC continues to recommend continuing reductions in the indirect graduate medical education component. I think that -- and there have been at times in the past single payer models proposed -- I mean all payer models, not single payer -- all payer models proposed for graduate medical education.

As far as I can see, there has neither been a mounting charge to increase the number of positions, and there hasn't been a

lot of support for doing away with graduate medical education funding. I think there would be -- It would be very difficult to do that. So they whittle at it, I think.

DR. DOCKERY: Are there other questions? Mr. La Porte?

MR. LA PORTE: So I am a little confused about the location of the bottleneck, because I heard two things. One is that there is a cap on the number of seats and funding, and then two is that the hospitals have their own restraints.

So is the bottleneck with the hospitals or with the government funding?

DR. NASCA: I don't understand your question.

MR. LA PORTE: I heard you explain that the hospitals aren't inclined to increase the number of residency positions. I also heard that there is a limit on the number of seats -- I mean there is a limit on funding.

DR. NASCA: Yes.

MR. LA PORTE: And so I am getting

confused. Let's say, for example, a hospital in Chicago wants to add more residency positions. Are they blocked from doing so because of their own constraints? Is that your point, or is it because, even if they applied, there wouldn't be funding?

DR. NASCA: Depends on the hospital. Both of those can be true in one institution. One can be true in one institution and not in another.

What is clear, for instance, is -- For instance, in the Commonwealth Medical School in -- the new medical school in Northeastern Pennsylvania, they are attempting to start residency programs in support of that medical school in the multiple specialties that you need.

Unfortunately, small numbers of residents from other institutions have rotated through the participating sites. So they have an existing cap with Medicare. They have an existing number that is very low. They cannot afford to start those residency positions,

because they will receive no medical education funding, incremental funding, from Medicare because of the cap.

So that institution -- it's purely money. In other institutions -- for instance, University of Chicago -- may not be able to increase its internal medicine residency because they have all of their beds covered. They have the appropriate numbers. Then in that situation, it wouldn't necessarily be cap money. It would be capacity.

DR. DOCKERY: Dr. Hallock.

DR. HALLOCK: The problem with the cap is exclusively one of limitation of funding.

DR. NASCA: Yes.

DR. HALLOCK: If a hospital chose to go over its cap, it could, if it could afford it.

DR. NASCA: Right. And that is exactly what is happening with these fellowships, because there is an economic equation that makes sense to them.

DR. DOCKERY: Dr. Crane?

DR. CRANE: Yes. I have a question for you. When we consider public and private hospitals, is there a differentiation in terms of foreign medical graduates and U.S. medical graduates that are accepted into some of those programs? Is it proportioned or do your standards prohibit that?

DR. NASCA: Our standards are neutral on the medical school of attendance. The entry criteria for any ACGME accredited program include ECFMG certification. So it is one of the -- There is no prioritization, either in our standards or in the eyes of the institutions. I think it is on an individual basis.

As regards particular types of institutions having a predominance of one origin or another of the trainee, I think that is largely institutional. It is not in any way accreditation related.

DR. CRANE: There is no regulatory requirement to --

DR. NASCA: There is no regulatory directive. We do not direct trainees in any direction, nor am I aware that anybody does.

DR. DOCKERY: Other comments or questions? Have you worked out the coordination between the institutional accreditation visit for the institutional requirements and then the program review of the residency training programs?

It is terrible when you have lived long enough that you lived through the installation of the institutional requirements and the grumbling and carrying on about they get the institutional visit and then they get the program visit, and how are those things going now?

DR. NASCA: Well, they are going grumblingly well, depending on where you are, I guess.

DR. DOCKERY: So nothing changes.

DR. NASCA: Nothing changes, and we are about to make it worse, because we are probably going to have a separate

institutional review for duty hours compliance around that philosophic issue that we talked about.

DR. DOCKERY: Would you briefly just tell us what the six competencies are, so that we all can know what those are, and you're thinking about a seventh, which you mentioned?

DR. NASCA: Medical knowledge, patient care, professionalism, communication skills and interpersonal relationships, practice-based learning and improvement, and systems-based practice.

DR. DOCKERY: Dr. Munoz, you had a question?

DR. MUNOZ: If the logjam breaks and the funding is lifted or the cap lifted, what do you think the -- or what is the estimation of the catch-up rate will be?

Given that the projection of increasing both U.S. medical graduates and an increased number of foreign medical graduates, would you, even if you started now, be able to

create enough slots that you wouldn't still run into the pinch?

DR. NASCA: I think that will be specialty specific. One of the things we are trying to understand is, you know, we know pretty much how fast you can create a medical school.

It takes between three or four years to go through the pre-accreditation process, depending on what time of the year you start, before you actually matriculate your first class. Then it is, obviously, three years -- or four years later then you graduate the class.

It probably takes almost as long to start a neurosurgical residency or a general surgical residency, the reason being that the infrastructure for the GME programs, especially around research and the breadth of clinical opportunities and faculty depth in all of those areas that is required is very similar to starting a medical school.

A lot of these people are small in

number -- for instance, neurosurgery or some of the subspecialties in surgery -- and there is significant difficulty in doing that and significant expense.

So I would anticipate that, were we to start tomorrow to expand, we would barely be coming online about this time. So I think the clock is running.

DR. DOCKERY: Again, thank you very much, Dr. Nasca.

(Applause.)

DR. DOCKERY: The committee will adjourn briefly to say goodbye to Dr. Nasca, while he also collects his technological accompaniments.

(Whereupon, the foregoing matter went off the record at 1:16 p.m. and went back on the record at 1:24 p.m.)

DR. DOCKERY: If Mr. James has returned with his entourage we will now hear the Dominican Republic. Are the guests from the Dominican Republic here, Mr. James?

MR. JAMES: I believe they are.

DR. DOCKERY: Okay, thank you.

MR. JAMES: Have you ever had déjà vu? I mean, I just dreamt I just was here not too long ago.

DR. DOCKERY: Well tell me, how did it go?

(Laughter)

MR. JAMES: I thought it went pretty well. But that was just my dream, of course.

DR. DOCKERY: Well this is the post-test.

MR. JAMES: This is the post-test? But I hate post-tests. All right.

Members of the Committee, I again will be presenting the report submitted by the Dominican Republic and you can find that again at Tab D.

The Secretary of State for Higher Education, Science and Technology is the entity responsible for evaluating medical schools within the Dominican Republic. In 2007 approximately $37 million in federal

student financial aid was awarded to students that enrolled in post-secondary institutions located within the Dominican Republic.

At the spring 2004 meeting, you determined that the Dominican Republic accreditation and approval process continued to be comparable to that used by the United States to accredit its medical schools. At that meeting you also requested that the country submit a report of its activities regarding its accreditation of medical schools within the country.

That report was reviewed at the spring 2007 meeting, and as a result you asked the country to provide an additional report covering three issues reviewed at your fall 2007 meeting. Your review of that report determined that only one of three issues was satisfactorily addressed, and you requested an additional report that covered the two remaining issues, as well as an additional issue that you raised.

That report again was reviewed at

the fall 2008 meeting with the determination that the country provide information on two issues, which would be reviewed at this meeting.

First, you asked the country to provide evidence that demonstrates that it collects and analyzes student outcomes measures.

The country responded by stating that it requires medical schools to achieve a 65 percent passage rate for all students taking the USMLE examination. It reiterated that as of January 1, 2008, all medical schools must require students from the United States to sign a form authorizing the release of USMLE test scores to the medical school in which they were enrolled. However, because this requirement had just been implemented, the data collected is incomplete.

The country also stated that beginning in 2009 it will conduct unannounced visits to verify that test results are in fact being collected. Further, it notes that

medical schools must submit an annual report that provides student data, including USMLE test information, and in fact the country provided a spreadsheet to demonstrate that it is collecting the data.

However, Department review of those spreadsheets observed that only dates were entered under the examination column, but no test results were entered. The staff also noted that no data had been entered for the majority of the students from the United States, that is, the dates for taking the test.

The country noted that it was going to meet with the accreditation committee to determine what standards would be developed regarding outcomes. The staff notes that it was not aware or has no knowledge about an accreditation committee and what role this entity plays in the evaluation of the country's medical schools.

Second, you requested that the Dominican Republic provide information

regarding student retention each year for each medical university.

The country responded by providing a spreadsheet that identified withdrawal rates for its 10 medical schools. However, the country again stated that it needs to meet with the accreditation committee to determine the standards that it will use to evaluate that data.

In conclusion, the country has responded to the issues raised by the committee. However, you may want to explore with the country two issues: one, the involvement of the accreditation committee in establishing standards for medical schools and what role the accreditation committee plays in the evaluation of medical schools; and two, how the country intends to gather licensing examination test data for the USMLE and Puerto Rican licensing examinations.

Currently the country has not demonstrated that it collects and evaluates test data. It simply gathers - it has only

provided evidence that it puts dates down for when I guess the test would be administered.

And further, you may want to explore how it intends to evaluate licensing examiner's patient examination pass rates and retention rates.

Representatives from the country are here to answer your questions that you may have and that concludes my remarks, and I am now available to answer any questions.

DR. DOCKERY: Thanks, Mr. James. Are there members of the Committee before we ask the representatives from the Dominican Republic to approach the table? Are the representatives from the Dominican Republic here? Please join the table. Please state your names and use the microphone and I invite you to make any comments you would like to make.

DR. HUYKE: Good afternoon. My name is Emilio Huyke. I am the consultant for the Dominican Republic and I will be speaking on their behalf.

MS. CESPEDES: Greetings Mr. President and other members of this honorable board. For us, the Dominican delegation, it is a pleasure to be again before you. According to the request of this committee we are delegation of Mr. Emilio Huyke. The mission of the coming, the spoken - asked the advisor of the ministry and of higher education. We would like to remind you once more of our compromise and best intention to cooperate with you. Thank you. My name is Rosa Cespedes. I am Director of Medical Education in the Dominican Republic.

DR. DOCKERY: Are there questions from members of the Committee before we go into executive session? **If we could ask our guests to please depart and they'll be called on when we open up again.**

EXECUTIVE SESSION

END OF EXECUTIVE SESSION

DR. DOCKERY: We can ask our guests to please return. And next we will start with India. And I understand that the Pakistani

representative is here and would be able to be heard today, so for those that would need to know, we will plan to hear Pakistan immediately after we complete India. Dr. Hong-Silwany, welcome again.

DR. HONG-SILWANY: Thank you. Good afternoon, Mr. Chairman and committee members. I will now summarize the analysis for the Medical Council of India submitted on behalf of the Government of India. The materials are behind Tab G. I will refer to the accrediting council as the MCI or the council.

In March 1997 this committee first determined that the standards and processes used by India were comparable to standards of accreditation applied to M.D. programs in the United States. In March 2003 you affirmed a prior determination of comparability. At the September 2004 meeting you requested that India submit a report on its accreditation activities involving its medical schools. This report was reviewed and accepted at the September `07 meeting.

The council is before this committee again for redetermination of comparability. Based on information provided by India, Department staff concludes that India's standards and processes for evaluating medical schools remain comparable to those used in the United States.

As you are aware, the Indian medical education system is a highly structured process that is based on educational inputs. Standards are prescribed in detail and regulation, and are verified by inspection teams during their site visits. Given the emphasis on educational inputs in the Indian system and the detailed standards that are specified for student examination format, content, and procedures, less attention has been directed toward the assessment of graduate performance outcomes in evaluating the effectiveness of the medical education curriculum and the quality of the clinical experience. However, goals, objectives, knowledge and skills are clearly

outlined for every curriculum requirement.

The Indian system also requires a very comprehensive onsite inspection in order to assess the quality of a medical education program. As a result, it appears that India's system remains comparable to the process used to accredit medical schools in the United States.

Representatives from India are here today and this concludes my presentation. I'm available to answer any questions you might have.

DR. DOCKERY: Thank you. Are there any questions from the committee before we welcome the representatives from India? Thank you.

Will the representatives from India please come forward? Good afternoon. Please use the microphone and introduce yourselves, and we would welcome any remarks that you would like to make.

DR. KUMAR: I am Dr. Ashwani Kumar, Professor of Microbiology at University

College of Medical Sciences. I am the representative of Delhi University and Medical Council of India.

DR. MISHRA: I am Dr. Vedprakash Mishra. I am member of the Executive Committee of Medical Council of India and also former chairman of the Postgraduate Committee of Medical Council of India. I am Vice Chancellor with the Health Sciences University in Nagpur.

At the outset, sir, we would like to record our sense of gratitude for this opportunity whereby we are before this learned committee for the purposes of re-validation of the parity which was accorded in the previous recommendation.

As far as the self-study for the evaluation report, which is there before us, there were concerns which were ventilated, which have been dealt by being part of the information. And I would just like to briefly put those three concerns which are put across. The first concern was about the preventive

and promotive healthcare aspects of the students admitted to medical school and medical colleges. Wherein we had brought it out very categorically that every student admitted to a medical school, which ultimately is affiliated to an examining university, the university by law stipulates that enrollment is subject to satisfaction of the physical status of the child, and simultaneously he is subjected to periodic health appraisals which are a condition precedent for the purposes of grant of affiliation by that university. So the bylaws are very speaking and that particular position is well in place in all the medical schools affiliated to various universities in the country.

The second proposition was pertaining to the grievance redressal of the students in the medical school to which we clarified that there is a grievance redressal cell, which is constituted in every medical school, and this is also a condition precedent for the purposes of grant of affiliation and

of the regulation of the respective universities to which the medical schools are affiliated.

The third chairman's recommendation was pertaining to the concerns of the faculty vis-a-vis the contradictions or conflicts, if any, between the professional and personal propositions. They're also the two mechanisms, standing mechanisms which are available in India. One is a standing grievance committee which a university has, which is open to teach the faculty and medical schools and simultaneously there is a university and college tribunal which is constituted for each of the universities which is responsible for the process of adjudication pertaining to any one of these grievances of various magnitudes which are structured and defined.

And the fourth concern which was put across was about the orientation and training of the inspectors who are conducting the onsite inspection of medical schools in

the country. To wit, the situation was that Medical Council has got full-time medical inspectors who are appointed on a full-time basis subject to fulfillment of the eligibility conditions and they are oriented in regard to what exactly the process of inspection is. The team, which comprises of the full-time inspector along with two inspectors who are drawn from a panel, which is prepared by the Medical Council of India. Out of the senior faculty members in public sector medical colleges who could be holding the rank of professor, maybe with minimum of seven years of experience, and they are oriented by the full-time inspector.

Other than this, Medical Council of India also conducts periodic update of how exactly the inspections are required to be conducted. Although the format of the inspection is heavily structured, it is almost like a checklist and therefore there is not much of a scope whereby a real rigorous training is required, but still, as an

abundant caution and in order to ensure that objectivity, transparency and accountability is worked in the entire process of onsite inspection, structuring of the mechanism along with periodic orientation which is structured and carried out by Medical Council of India, for the group of inspectors who are out of - the panel of whom is made along with the full-time inspectors.

So these were the four concerns which were put across which have been replied to and in the context of that we are here to answer any questions, if any.

DR. DOCKERY: Thank you very much. Are there questions from the Committee before we go into executive session?

MR. La PORTE: So just a quick follow-up on what you said. So if I understand, points one, two, and three that you address I think with regards to student health and grievances - I can't recall the third one - they would fall under the surveillance, I guess, of the University

Grants Commission?

DR. KUMAR: Not - the University Grants Commission basically is the vital body. Like Medical Council of India is for medical education, University Grants Commission is for higher education. But you're right, medical universities also fall under University Grants Commission and therefore the affiliating conditions and the various bylaws which the universities are expected to make will be in the context of a central, you know, a model act, or a model bylaw, which is stipulated by University Grants Commission.

MR. La PORTE: Right.

DR. KUMAR: So that basically ensures uniformity of bylaws all over the country and as you're right, it is the accreditation of these universities is subject to by the National Accreditation and Assessment Council which is a body created by University Grants Commission, autonomous in nature. Therefore it is a dual control. The educational component of medical education by

Medical Council of India and the other associated conditions which are governed by University Grants Commission in regard to universities, they will be falling under those bylaws.

DR. DOCKERY: One question which I think is good to be answered in the public forum is when you were here before and as we've looked at the applications there's concern about the proliferation of private medical schools in India and how you were addressing that. Do you have any updated information in terms of how you're addressing those concerns?

DR. KUMAR: Absolutely. Yes. Chairman, because you have brought a very right concern because this is also the concern which the Medical Council of India is going to be sharing with this committee. Because if you take into consideration the report, it contemplates 284 medical colleges when we applied, but when I am before you, I have five more medical schools added and I have 289

medical schools under Medical Council of India of which 137 are in public sector and remaining are in private sector. But as far as the standards, regulation and other propositions are concerned, regulations are common, mechanisms are similar, and therefore the standards which are required to be involved by the Medical Council of India irrespective of the nature of the college whether it is private sector or public sector, regulatory control is uniform, standards prescribed are uniform, monitoring measures are uniform, and therefore the parity of standards amongst the two are absolutely maintained as it is required to be.

DR. DOCKERY: Dr. Shah?

DR. SHAH: All medical schools are affiliated with the university, or are there any freestanding medical schools?

DR. KUMAR: There aren't. You see, ultimately we have an affiliated character, the three-tiered mechanism. Medical Council of India is a unitary body for controlling the

entire standards of medical education, all medical colleges. But invariably it's a condition precedent that if a medical school is required to be open, first there has to be an affiliation with the university which ultimately will be examining the students and resulting in conferment of a degree. Because the recognition schedule which we have is university-based and not institution-based.

DR. DOCKERY: Thank you very much. If we could ask our guests to please depart.

EXECUTIVE SESSION

END OF EXECUTIVE SESSION

DR. DOCKERY: Okay. We will take just a 10-minute break and then we will consider Pakistan, to be followed by the United Kingdom.

(Whereupon, the foregoing matter went off the record at 2:13 p.m. and went back on the record at 2:22 p.m.)

DR. DOCKERY: Mr. Sneed.

MR. SNEED: Good afternoon, Dr. Dockery, Committee members, and guests. I

will summarize the analysis of the application for redetermination submitted by the Pakistan Medical-Dental Council. Hereafter I will refer to as the agency or the PM&DC. You will find materials relating to the analysis under Tab H.

In March of 1997 this committee initially determined that the standards used by the PM&DC were comparable to those used to accredit medical schools in the United States. In March of 2003 this committee again reviewed the PM&DC accrediting standards and reaffirmed its prior determination that the standards were comparable to the accrediting standards supplied to medical programs in the United States and requested a report of its activities. In March of 2004 this committee reviewed and accepted the PM&DC report of its accrediting activities. This committee also requested that the council submit another report on its accrediting activities for review at its March 2005 NCFMEA meeting. However, in 2005 this Committee's review

activities were suspended. In September 2007 this committee accepted the report and requested that Pakistan reapply for comparability determination at the March 2009 NCFMEA meeting, which is the subject of today's presentation.

Department staff have reviewed Pakistan's guidelines and supporting documentation and found the following. The standards of accreditation used by the PM&DC to accredit medical schools offering programs leading to a medical doctorate degree are closely comparable to standards of accreditation applied to MD programs in the United States. However, it should be noted that there are some issues the Committee may want to explore with the country's representatives. These include a concern that the agency's policies are not clear regarding the requirement for maintaining the confidentiality of student records. If the - and if the country intends to use a percentage of post-graduation achieved by students from

each medical school it needs to clarify what is meant by post-graduation. If the country intends to use pass rates achieved by students on international examinations, the country needs to clarify whether a significant number of students take these examinations.

Based on a review of the report submitted by Pakistan, the Department staff concludes that Pakistan has provided a response to all but two concerns requested by the Department.

There have not been any known Title IV funds dispersed to this country to date. There are representatives present today to receive questions. This concludes my report.

DR. DOCKERY: Thank you, Mr. Sneed. Are there questions from members of the committee for Mr. Sneed? Then we welcome the representatives from Pakistan to come forward please. We welcome you and thank you for coming such a long distance to be with us. And if you would please use the microphones and introduce yourselves and let us know your

names and your respective positions.

DR. AKBAR: I'm Dr. Ahmad Nadeem Akbar. I'm the Registrar of the Pakistan Medical & Dental Council and the CEO.

DR. DOCKERY: And your other colleagues?

PROF. A.J. KHAN: I'm Professor A.J. Khan. I've been the principal of and established a few medical colleges for the government. I've been Director of Health of Government of Pakistan. I've also been a federal minister and I'm very closely connected with Pakistan Medical Council and medical education in Pakistan.

PROF. UMAR KHAN: I am Dr. Umar Khan. I am professor of physiology and also associate dean at my university. And I'm a member of the Pakistan Medical & Dental Council.

DR. DOCKERY: Thank you. Are there any remarks to the committee?

DR. CRANE: Thank you very much. There are a few things which I want to say.

This gives me immense pleasure to reiterate the fact that the Pakistan standards of education were declared comparable to U.S. standards by the NCFMEA in 1997. And the NCFMEA has reaffirmed the comparability since then, so we are very grateful for that.

I would like to share with the committee that the graduates of our system are doing exceedingly well in the U.S. system as IMGs. And there are a lot of U.S. nationals who come and study in Pakistan and then they join back your system in the U.S. Although study and review of emerging trends are continuously carried out by the Pakistan Medical & Dental Council, to stay abreast with the emerging trends only the prudently adopted measures are included, and there is no substantial change in the education protocols and standards. We can all take your questions.

DR. DOCKERY: Are there questions by members of the Committee before we go into executive session? If we could ask our guests

please to depart and we'll go into executive session.

EXECUTIVE SESSION

END OF EXECUTIVE SESSION

DR. DOCKERY: Have a safe trip home. Thank you very much. We'll next hear the United Kingdom, please. Mr. James, welcome back again.

MR. JAMES: Thank you, Mr. Chair.

DR. DOCKERY: And I notice in the - and I mentioned this to some of the staff earlier, that they offered to have video conferencing for their appearance today. And how seriously did you take that?

MR. JAMES: Well, I think that the answer is that we would have liked to have done that, but unfortunately it just was not feasible to do that through the hotel here I think. I think it was even teleconferencing, I believe is what they were talking about. So it just, I think price-wise, just was not feasible for us to look at that. But we would have liked to have done that. I mean, that

would have been ideal, I think.

DR. DOCKERY: I remember though that the price tag for that single event would have been $7,000?

MR. JAMES: That's what I heard, yes.

DR. DOCKERY: So.

MR. JAMES: That's a great dive trip to Australia.

DR. DOCKERY: Yes. Roundtrip.

MR. JAMES: Exactly.

DR. DOCKERY: Mr. James.

MR. JAMES: Thank you. Good morning, members of the Committee. I will be presenting the application for reconsideration of comparability submitted by the United Kingdom which I shall refer to as the UK. The documents can be found at Tab N.

The UK was first reviewed at the fall 1995 meeting of the National Committee on Foreign Medical Education and Accreditation. Continued comparability was granted at your fall 2001 meeting. In 2007 approximately $19

million in student financial aid was awarded to students attending post-secondary institutions in the UK.

In its current application the UK outlined a process that is in most ways comparable to the evaluation process used to evaluate medical schools in the United States. However, the standards used by the UK to evaluate the medical education in some areas are broad and do not provide any specific guidance regarding to the guidelines outlined in the Department's questionnaire. For example, the standards neither provide any specific guidance on what subject areas should be included in the basic science component of the medical education curriculum, nor do the standards outline core clerkships that all students must have.

Department staff reviews of site visit reports verify that the teams do review the curriculum and some reports identified some basic science courses that are offered. However, the staff could not determine that

the country requires all the elements of the basic science as outlined in the guidelines to be taught in medical schools.

Similarly, site visits verify that teams evaluate the clinical portion of its medical education program, but there's no indication of what clinical rotations are required.

In other instances there were no standards, written standards, for some of the guideline requirements. For example, there are no written standards regarding the qualifications required by the chief academic officer of the medical school, or the involvement of the faculty in hiring, retention and discipline of faculty members.

In these instances the GMC, the General Medical Council, who is the entity responsible for accrediting the medical schools within the United Kingdom stated that these issues are under the purview of the universities.

The analysis of the country's

application led staff to identify seven issues the committee may want to explore further with the country. These same issues were raised in the country's application in 2001 in a meeting between a Committee member, Department staff, and the Chair of the General Medical Council's Education Committee was arranged to explore these very issues. As a result of that meeting, the country was able to satisfactorily answer all of the Committee's concerns. However, the Department's staff analysis of the country's current application and their response to the analysis of their application did not fully resolve the seven issues.

Therefore, you may want to gather more information from the UK on the following issues: whether the country has standards or how the country determines if the qualifications of the chief academic officer of the medical school are appropriate; the involvement of the faculty in the hiring, retention and discipline of faculty members;

whether the country ensures that all basic sciences are included in the curriculum; whether the country ensures that all students must take all of the clinical clerkships described in the guidelines; whether the country requires disciplines that support the fundamental clinical subjects such as diagnostic imaging and pathology; how the country ensures that a student is given the opportunity to challenge the accuracy of their student record; and finally, whether the country has written policies that require medical schools to obtain approval regarding offering new courses, major changes to the curriculum, or the assessment of the program.

In summary, the Department staff believes that the medical education program is comparable in most ways to that used in the United States. Further, based upon the documentation submitted by the UK, based upon the review of those documents provided by the UK, Department staff believes that the graduates of medical schools are fully

qualified to enter the field of medicine. The main difference between the process used to evaluate medical schools in the United States and the UK are in the lack of specificity of the standards in some areas.

There are, as you are aware of, no representatives from the UK present today. And that ends my prepared comments and I am now available to answer any questions.

DR. DOCKERY: Thank you, Mr. James. Are there questions from the members of the committee before we go into executive session? If we could ask our guests to please depart then.

BEGIN EXECUTIVE SESSION

END EXECUTIVE SESSION

DR. DOCKERY: We can ask our guests to return. And let me ask the Committee how you would like to function for the rest of the day. I have about six issues that I need to talk with the committee about to get some direction. It's now 5 after 3:00. There is not a representative here from Canada. It

would be my suggestion that we hear Canada and then we close the deliberations on the countries today and then go to deal with our business and try to anticipate that we could adjourn a few minutes before 5:00. What is the favor of the Committee? Okay, in that case then we'll go ahead and hear Canada. Let me interrupt our progress of the meeting to recognize a representative from Pakistan who would like to make a presentation.

PROF. A.J. KHAN: Thank you very much, sir. This is just - we are really, we have come from far off and we are impressed, and particularly impressed and I'm sure not only that we have given some information. We have learned a lot. And from Pakistan Medical & Dental Council it is just a memento as you can see. It's not a very gainful thing, but it'll just perhaps remind you that we came here and you were kind to us and you listened to us and we learned from you. And according to the United States rules it does not cost even, I think, ten dollars. It's less than

that. So, I understand you have got a rule that it should be less than twenty dollars. This is much less than that. But this will - perhaps you will like it, the reminder that we came here. And you have been kind to us. And of course, because of we're coming here and all these things, we are learning so much. And we continue. And we also admire what you are doing here. The questions that you asked are so good, so nice, and so informative and useful for us. If I may give this to each member.

DR. DOCKERY: Thank you very much. Rather than taking your time, let us thank you with our applause and if you'll just leave them on the table, then I promise you that each of us will pick them up and we also admire the box in which they're contained. So thank you very much.

(Applause)

PROF. A.J. KHAN: Thank you.

DR. DOCKERY: Staff will tell you to where to leave them.

PROF. A.J. KHAN: Thank you very much.

(Canada)

DR. DOCKERY: Thank you. Dr. Jones, we welcome you back again.

MS. JONES: I shan't go until Dr. Dockery returns. I think that your chairperson should be in the room.

DR. DOCKERY: Just for you all to know, I refused a photograph. Dr. Jones?

MS. JONES: Good afternoon, Dr. Dockery, and Committee members. I am pleased to present you with the summary of the e-petition for comparability of redetermination submitted by the Committee of Canadian Medical Schools, or CACMS. It's found behind Tab A.

Just a little background on CACMS shows that in February 1995 this committee originally determined that the CACMS used accreditation standards and processes in Canada that were comparable to the standards of accreditation applied to the M.D. programs in the United States. Similarly, the CACMS

reports that it is the Canadian counterpart to the Liaison Committee on Medical Education, or LCME, and uses the LCME standards and processes to accredit the Canadian medical schools.

Since the initial comparability determination in 1995, the CACMS has received continued redeterminations from this Committee. CACMS has also submitted reports requested by the Secretary that included, one, an overview of its accreditation activities, two, changes to the laws and regulations, three, changes to the standards, processes, and procedures, and four, a schedule of upcoming accreditation activities. After returning from a break in this committee's activities in 2007, the Department postponed the NCFMEA's review of Canada until this meeting to allow the CACMS to compile information requested by your executive director and Department staff.

The executive director specifically requested, among other things, that the CACMS

provide, one, written evidence of the accreditation relationship that exists between the LCME and CACMS, and two, explain what acknowledgment, recognition, or delegation of authority the CACMS had received from any governmental entities, either national and/or provincial, to serve as the insurer of quality medical education programs leading to the medical degree or its equivalent in Canada.

The CACMS Secretary, Dr. Nick Busing, spelled B-U-S-I-N-G, submitted a few documents and participated in a telephone conference with Department staff. The conference focused on identifying the entity responsible for approving opening and closing of medical schools in Canada. Dr. Busing explained that ministries of education in each province have the responsibility to open and close a medical school because no federal Department of Health or Department of Education exists in Canada. Additionally, two separate decision meetings on the Canadian medical schools occurred. The LCME makes an

accrediting decision on a Canadian medical program. Then the CACMS also makes an accrediting decision which may have different findings. Each group merges their respective findings and sends the combined findings to the school in one decision letter. The decision letter is signed by both the LCME and CACMS representatives.

The Department of Education's Office of Federal Student Aid provided the latest data on the federal student loan program disbursements under the Federal Family Education Loan program at 13 of the 17 accredited schools in Canada. For Fiscal Year 2007-2008, 1,391 students attended Canadian public universities that had medical schools and received nearly $19 million in loans. The 2006 cohort rate, default rate shows that there were 703 individuals in repayment status with six individuals in default for a current default rate or the last known default rate at 0.9 percent.

The information provided by the

CACMS in its application for redetermination of comparability for accreditation of medical colleges is, of course, the subject of this analysis. First, the standards of accreditation used by Canada to accredit medical schools offering programs leading to the M.D. degree are the same standards of accreditation that are applied to review medical programs in the United States. Second, the CACMS has submitted written documentation demonstrating the implementation of its accreditation process.

Through Dr. Busing the CACMS, it has reported that medical schools have a relationship with the provincial governments related to the approval, the opening, and closing of a medical school, and the licensure of medical graduates who complete training at a CACMS accredited medical school. Yet, the CACMS has not reported on the relationship it has with Canada. Therefore, this committee may want to ask CACMS to provide evidence demonstrating that a relationship exists with

Canada and that the country accepts the agency as the organization it relies upon for ensuring that the accredited programs provide quality medical education.

No representatives from the country or CACMS are present today. However, I will respond to any questions that you have regarding the staff analysis. Thank you.

DR. DOCKERY: Thank you, Dr. Jones. Are there any questions from members of the committee before we go into executive session? Thank you. If we could ask our guests to please leave again.

(Whereupon, at 3:40 p.m., the proceedings went into Closed Session and the Open Sessions ended for the day.)